Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

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(Rev. 1, 10-01-03)

AB-00-107

A - Transfer of Initial Medicare Secondary Payer (MSP) Development Activities to the Coordination of Benefits Contractor (COBC)

On November 1, 1999, CMS awarded the COB Contract. The COBC will consolidate activities that support the collection, management, and reporting of all other health insurance coverage of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. In April 2000, the COBC implemented the first two phases of the contract, which included the Initial Enrollment Questionnaire and the IRS/SSA/CMS Data Match. Effective January 1, 2000, the COBC assumed responsibility for virtually all initial MSP development activities formerly performed at Medicare fiscal intermediaries (FIs) and carriers. This means the COBC is charged with ensuring the accuracy and timeliness of updates to the Common Working File (CWF) MSP auxiliary file. Virtually all prepay MSP development activities are the responsibility of the COBC. The COBC does not process claims, nor handle any mistaken payment recoveries or claims specific inquiries (telephone or written). The COBC is responsible for developing to determine the existence or validity of MSP for Medicare beneficiaries. The COBC handles all MSP related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries. These calls can come from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, suppliers and Common Working File (CWF) assistance requests received from intermediaries and carriers.

The COBC is primarily an information gathering entity. The COBC is dependent upon various sources to collect this information. With limited exceptions, FIs and carriers are no longer responsible for initiating MSP development and making MSP determinations. It is imperative that any information they receive that might have MSP implications be forwarded to the COBC in a timely and accurate fashion. Only with this timely and accurate information can the COBC evaluate all relevant information to make the correct MSP determination and appropriately update CWF so that claims will be processed correctly. Once the MSP record has been established on CWF by the COBC, Fis, and carriers will continue to be responsible for all activities related to identification and recovery of MSP-related debts.

There must be a very close working relationship between the COBC and all FIs and carriers. The COBC Customer Service number is 1-800-999-1118. This number is available for use from anywhere in the United States. The COBC Customer Service number will be operational 8:00 a.m. to 8:00 p.m. eastern standard time, Monday through Friday except holidays. Fiscal Intermediaries and carriers should use this number for

routine inquiries to the COBC. In addition, the COBC will provide each FI and carrier with the name, private telephone number, and fax number of a primary and a backup contact for use in instances where special situations arise that need immediate attention. Fiscal Intermediaries and carriers provide the COBC with the name, private phone number, and fax number of their primary and backup MSP contact.

The following provides a description of the activities that are included in initial MSP development and the necessary action(s) of FIs and carriers.

10.1 - FI and Carrier MSP Auxiliary File Update Responsibility

(Rev. 1, 10-01-03)

AB-00-107, AB-02-022, AB-02-107

The capability to update the CWF MSP auxiliary file is, essentially, a function of only the COBC. Fiscal Intermediaries and carriers do not have the capability to delete any MSP auxiliary file records, including those they have established. If they believe a record should be changed or deleted, they must use the COBC Electronic Correspondence Referral System (ECRS) (discussed in §10.2), CWF Assistance Request option, to notify the COBC. They shall process claims in accordance with their existing claims processing guidelines.

Medicare intermediaries and carriers retain the responsibility of adding termination dates to MSP auxiliary records already established on CWF with a "Y" validity indicator, where there is no discrepancy in the validity of the information contained on CWF.

There are only four instances in which the FI and carrier will retain the capability to update CWF. They are:

1 - The FI or carrier receives a phone call or correspondence from an attorney or other beneficiary representative, beneficiary, third party payer, provider, another insurer's explanation of benefits or other source that establishes, exclusive of any further required development or investigation, that MSP no longer applies.

Examples of such contacts include a telephone call from a beneficiary to report retirement or cessation of group health insurance or a letter that contains acceptable information that personal injury protection benefits have been exhausted. The FI or carrier should post a termination date to the MSP auxiliary record using a "Y" validity indicator. They should update CWF within the lesser of:

1. 10 calendar days from completion of the evaluation, or

2. 30 calendar days of the mailroom date-stamped receipt/date of phone call, as applicable. Fiscal Intermediaries and carriers do not have the capability to alter an existing termination date.

EXAMPLE 1

Scenario

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

Fiscal Intermediary/Carrier Action

Check for matching auxiliary record on CWF and terminate, if no conflicting data are present. Do not transfer the call to the COBC.

EXAMPLE 2

Scenario

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

Fiscal Intermediary/Carrier Action

Check for matching auxiliary record on CWF and terminate, if no conflicting data are present. Do not transfer the call to the COBC.

EXAMPLE 3

Scenario

The FI/carrier receives written correspondence that benefits are exhausted for an automobile case.

Fiscal Intermediary/Carrier Action

- Check for matching auxiliary record on CWF. If FI/carrier is the lead, it should terminate in accordance with existing guidelines (e.g., accounting of moneys spent).

- If a FI or carrier is not the lead on the case, it should refer the correspondence to the lead contractor based on the pre-COB guidelines as outlined in the fiscal year (FY) 2001 MSP post-pay Budget and Performance Requirements (BPRs). The FI/carrier should not forward the correspondence to the COBC.

EXAMPLE 4

Scenario

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

Fiscal Intermediary/Carrier Action

Check for matching auxiliary record on CWF and terminate if no conflict in evidence is presented. Do not transfer the call to the COBC.

EXAMPLE 5

Scenario

The FI/carrier receives information that a liability case is no longer being pursued.

Fiscal Intermediary/Carrier Action

Check for matching auxiliary record on CWF. Forward to COBC for deletion via ECRS.

2 - The FI or carrier receives a claim for secondary benefits and could, without further development (for example, the explanation of benefits from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim.

The FI or carrier must use a validity indicator of "I" to add any new MSP occurrences (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). It must update CWF within 10 calendar days from completion of the evaluation. It cannot submit a new record with a "Y" or any record with an "N" validity indicator.

3 - The FI or carrier receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development.

It must add the MSP occurrence using an "I" validity indicator (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). It must update CWF within 10 calendar days from completion of the evaluation.

The FI or carrier transmits "I" records to CWF via the current HUSP transaction. The CWF treats the "I" validity indicator the same as a "Y" validity indicator when processing claims. "I" records should only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will be rejected with an SP 20 error code. Receipt of an "I" validity indicator results in a CWF trigger to the COBC. The COBC develops and confirms all "I" maintenance transactions established by FIs or carriers. If the COBC has not received information to the contrary within 100 calendar days, the COBC automatically converts the "I" validity indicator to a "Y". If the COBC develops and determines there is no MSP, the COBC deletes the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to the FI or carrier on its claim attachment or unsolicited refund documentation. If the FI or carrier has the actual date that Medicare

became secondary payer, it shall use that as the MSP effective date. If that information is not available, it shall use the Part A entitlement date as the MSP effective date. It may include a termination date when it initially establishes an "I" record. It may not add a termination date to an already established "I" record.

The following are mandatory fields for MSP records with a validity indicator of "Y" and "I":

- Health Insurance Claim Number;
- MSP code;
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name;
- Patient relationship; and
- Insurance type.

Chapter 6, §40.8, contains the CWF MSP utilization error codes, descriptions, and resolution for FI and carrier use in correcting MSP utilization error codes.

10.2 - COBC Electronic Correspondence Referral System (ECRS)

(Rev. 5, 12-22-03)

As of January 1, 2001, the COBC assumed responsibility for virtually all activities related to establishing MSP periods of coverage at CWF that result from initial MSP development activities. Since FIs and carriers received a great deal of MSP information, a system was needed to transfer that information to the COBC for its evaluation to determine if MSP development is necessary. In addition, since FI and carrier ability to send update transactions to CWF had been severely restricted, there was a need for a system to allow it to easily submit requests to the COBC to apply changes to existing MSP records at CWF. In order to meet these requirements, the COB developed and maintains a mainframe Customer Information Control System (CICS) application. This application, the COBC ECRS, allows FI and carrier MSP representatives to fill out various online forms and electronically transmit MSP information and CWF MSP assistance requests to the COBC. For CWF assistance requests or MSP inquiry referrals, information should be electronically forwarded, via ECRS, to the COBC within *45* calendar days of the FI or carrier mailroom date-stamped receipt. Phone calls must be referred via ECRS within two calendar days of receipt of the phone call. If requested, the FI or carrier must fax to the COBC within five business days of request, a copy of any

correspondence or substantiating information related to the electronic referrals. The COBC makes such a request via phone by contacting the initiator of the referral.

The COBC's ECRS is operational from 8:00 a.m. to 8:00 p.m. (EST), excluding weekends and holidays. The FI/carrier data centers will be notified during extended periods of ECRS downtime. *Problems encountered by data centers during testing should be reported to GHI's Help Desk technical support staff at (212) 615-4657. You may also e-mail your questions or issues to the COBC via Internet address at COB@ghimedicare.com. If you are unable to receive technical assistance from GHI's Help Desk, or your issue has not been resolved, please contact Alberta Smythe from Group Health Incorporated (GHI) at (646) 458-6694. If you still cannot obtain information or your issue continues to go unresolved, please contract Danielle Barbour (CMS) at 410-786-6468.*

ECRS issues can be e-mailed to the COBC at cob@ghimedicare.com. If FIs and carriers do not receive a response to their inquiry or issue within seven business days, they should contact their RO for assistance.

FIs and carriers should not contact GHI's help desk for routine ECRS processing issues. They should report connection problems or systems failures or crashes directly to GHI's technical support staff at 212-615-4657 or 212-615-4677.

Congressional inquiries, however, will not be referred to the COBC using ECRS. If the question(s) posed in the congressional inquiry fall solely under the purview of the COBC, the FIs or carriers must telephone their dedicated COB Consortia contact below and notify him/her that they are faxing a copy of the inquiry. They should close these items in their correspondence control system. If the inquiry contains some questions that the FI or carrier would appropriately answer and others that the COBC would appropriately answer, the FI or carrier will be responsible for sending a consolidated response to this inquiry. FIs/carriers should contact their dedicated COBC contact to request the necessary language to respond to the COBC's portion of the inquiry. The COBC will provide the necessary language within five business days of their request.

If an FI or carrier is preparing background information in association with a hearing, it may contact its COB consortia contact if further development or research is warranted in to validate the existence or nonexistence of an MSP situation. The COBC will handle these with the same urgency as a congressional inquiry.

A - COB Consortia Contacts

There are only four instances in which the FI/carrier may contact its COB consortia representative. They are:

1. Congressional inquiries (see above);

2. Preparing background information for a hearing;

3. ECRS processing issues; and

4. Status of ECRS CWF assistance request.

Contact your CMS Regional Office MSP Representative for the most current list of Consortia Representatives.

B - IEQ and IRS/SSA/CMS Data Match Referral Process

Effective November 1, 2000, FIs and carriers request changes to IEQ and Data Match auxiliary records on the CWF using the ECRS, CWF Assistance Request option.

C - MSP Activities

Effective January 1, 2001, FIs and carriers request changes to all MSP auxiliary record types on the CWF using the ECRS, CWF assistance request option.

ECRS User Guide v7.0 is contained in Attachment 1 of this chapter to assist FIs and carriers to effectively communicate their CWF Assistance requests and MSP Inquiries. Medicare contractors should contact their RO MSP Coordinator if they have questions regarding the changes within MSP Manual regarding ECRS 7.0 If you are unable to resolve your inquiry with the RO, you may contact Pat Murphy (CMS-CO) at PMurphy2@cms.hhs.gov or at 410-786-8123.

Submission of ECRS transaction; including but limited to cases where FIs and carriers receive ECRS errors/rejects which prevent successful transmissions to the COBC or in cases where there is difficulty understanding the information or instructions contained within the reference manual, they should contact their COBC Consortia Representative. Problems with an ECRS access code should be reported to Joanne Pierce-Morrison at 646-458-6680 .

The FI and carrier must allow 15 days for the COBC to respond to their CWF assistance request. If, after 15 days, there has been no update to CWF or a response to their request, they may contact the COBC at the customer service number. However, if they have a high priority request (i.e., Congressional or a second request), they may contact the COBC at (646) 458-6600. This number is only to be used for requests related to an IEQ and/or Data Match priority.

10.2.1 - ECRS Functional Description

(Rev. 5, 12-22-03)

- FI or carrier receives MSP lead information or determines that a change to an existing CWF MSP record (other than the addition of a termination date) is needed.

- FI or carrier signs on to its Medicare CICS region on its processing data center's mainframe.

- FI or carrier types in the transaction name of the new COB information exchange application and hits Enter.

- A menu displays, from which FI or carrier chooses either the option to create an MSP Inquiry (to report MSP information) or a CWF Assistance Request (to request a change in an existing MSP record).

- The applicable detail screen displays and FI or carrier enters data for its request. The application has built-in edits so that required data elements are entered before the request can be completed. Edits permit only valid values to be entered in each field. The COBC provides the FIs and carriers a user manual for the application.

- Once the FI or carrier has completed data entry, it presses an assigned key and the information is stored on a database table or file on the COBC's mainframe.

- In the next batch cycle at the COBC site, this request is processed. The COBC's system updates a status field on the request in ECRS. Once a final determination has been made, the COBC updates CWF, as appropriate.

- FIs and carriers may log back on to ECRS to check on the status of their request, including final determination.

- The ECRS system provides FIs and carriers the ability to create on-screen reports (for example, to do consolidated status checks on all their referrals or lead contractor assignments).

10.2.2 - Technical Overview - Impact on FI/Carrier Data Centers

(Rev. 5, 12-22-03)

This CICS application functions much like the CWF Health Insurance Master Record (HIMR) application. This is an online CICS transaction running in a mainframe environment. Different components of this application execute on the COBC's mainframe and the FI and carrier data centers' mainframes. Software modules were developed in COBOL II or COBOL OS390. No files were created or stored at the FI or carrier data center. No batch processing is required by the FI or carrier data center. Fiscal Intermediaries and carriers can access the system with a standard, mainframe terminal emulator. A PC workstation is not required.

The connection to the COBC's data center from FI and carrier data centers is accomplished using the ATT Global Network (once known as Advantis). All FIs and carriers, and the COBC, have access to this network and use it to transmit data to the CMS data center and CWF hosts. To establish a link or connection to the COB data center through this network, Virtual Total Access Method (VTAM) node definitions and ATT Global Network accounts were established. This required some action on the part of each data center.

10.3 - Providing Written Documents to the COBC

(Rev. 1, 10-01-03)

AB-00-107

Fiscal intermediaries and carriers do not routinely submit paper documentation to the COBC. However, if requested by the COBC, they must submit written supporting documentation via fax to the COBC within five business days of their receipt of the request. The request consists of a phone call asking the FI to fax this information. The COBC fax numbers are (646) 458-6760 and (646) 458-6762.

In those instances when the FI or carrier must mail paper documents to the COBC, it uses the following address:

MEDICARE - Coordination of Benefits Contractor
MSP Claims Investigation Project
P.O. Box 5041
New York, NY 10274-5041

10.4 - FI and Carrier Record Retention

(Rev. 1, 10-01-03)

AB-00-107

Fiscal intermediaries and carriers are responsible for retaining paper documentation that they do not forward to the COBC following current CMS document retention guidelines, including the assignment of a document control number for their use in subsequent retrieval. However, also see §10.7, which requires the contractor receiving a liability, no-fault or workers' compensation inquiry to forward all associated documentation to the designated lead contractor.

10.5 - Notification to FI or Carrier of MSP Auxiliary File Updates

(Rev. 1, 10-01-03)

AB-00-107

Fiscal intermediaries and carriers can log on to ECRS daily to generate a daily ECRS report. The daily ECRS report shows the status of referrals submitted through ECRS. The daily ECRS report also contains the status on beneficiaries for which the COBC has made a change in the MSP auxiliary record and/or for which the FI or carrier may have an interest. For example, the ECRS report reflects an inquiry sent to the COBC on this beneficiary in the past, or that CWF indicates it has processed a claim for this beneficiary. The COBC may not always be aware that the FI or carrier has an interest

in a particular beneficiary. The FI or carrier should then check CWF to determine the exact update that has been made by the COBC.

10.6 - Referring Calls to the COBC

(Rev. 1, 10-01-03)

AB-00-107

The COBC Customer Service number is (800) 999-1118. All questions, regardless of source, on any of the activities listed in §10.7 and §10.8 should appropriately go directly to the COBC. Fiscal intermediaries and carriers shall offer to transfer telephone calls on any of the activities listed in §10.7 and §10.8 to the COBC Customer Service number. Where the FI or carrier phone system has the capability, it shall transfer the call to the COBC through its automated response unit (ARU) utilizing a new script option(s). If the FI or carrier does not have this capability, it shall transfer the call through a manual transfer process that does not require the caller to dial another number. If it has neither capability, it shall take the information from the caller and refer the issue to the COBC via ECRS. Also, it shall provide the caller with the COB Contractor's toll-free Customer Service number and direct the caller to place any follow up calls to the COBC. The FI or carrier shall always provide this number to the caller.

10.7 - Changes in FI and Carrier Initial MSP Development Activities

(Rev. 5, 12-22-03)

Effective January 1, 2001, FIs and carriers no longer perform MSP development (that is, investigation to determine if another payer is primary to Medicare, including the development activities associated with adding or updating a record on CWF) related to the activities listed below. They still handle inquiries that are claims specific. The COBC does not handle Veterans Administration situations.

The COBC is the first point of contact for all initial MSP development. The COBC uses a variety of investigational tools, such as MSP questionnaires, telephone contacts, and data exchanges, to solicit the information necessary to determine if there is an MSP situation. It has sole responsibility, with exceptions noted in §10.1, for establishing CWF MSP records to reflect MSP situations.

In no-fault, workers' compensation, and liability situations, the COBC notifies the beneficiary of Medicare's potential recovery right as described in §10.8.1, §10.8.2, and §10.8.3. The COBC determines the lead contractor pursuant to CMS' guidelines and forwards all case documentation within its possession to the lead contractor. For recovery efforts in non-GHP situations, once an MSP record has been established, the COBC advises the beneficiary, attorney or other beneficiary representative, and/or potential or actual liable party that they will be contacted by the lead contractor for further recovery case development. If the COBC is unsuccessful in its attempts to

contact the beneficiary or attorney or other beneficiary representative based on the information it received from the FI or carrier, the COBC notifies the lead contractor if there is sufficient information to identify the lead contractor or notifies the referring contractor if there is insufficient information to identify the lead contractor. The referring FI or carrier, whether lead or not, follows up as appropriate and re-refer the issue to the COBC, if necessary.

In no-fault, workers' compensation, and liability situations, the COBC indicates in ECRS the lead contractor. The referring FI or carrier can check ECRS daily to determine the lead contractor in instances where it sent the initial referral through ECRS to the COBC. It can also query ECRS to determine the lead for any established liability situation. The FI or carrier that has documentation related to the case but is not the lead contractor must send all original documents (exclusive of claims) to the lead contractor within five calendar days of its CWF update. Documentation includes any materials it received or developed.

In cases where employer information is not pertinent (liability and no-fault), the COBC enters attorney or other beneficiary representative information, if appropriate, in the employer name and address field of the CWF MSP auxiliary record. Fiscal Intermediaries and carriers can check ECRS to determine if the beneficiary *representative is an attorney or non-attorney.*

The following provides the activities that are included in initial MSP development and FI or carrier necessary action as a result of the transfer of these responsibilities to the COBC.

A - Secondary Claims Development Process

If the FI or carrier receives a secondary claim for which there is no related CWF MSP auxiliary record and the claim contains sufficient information to create an "I" record, the FI or carrier follows the instructions in §10.1. If it receives a claim for secondary payment that does not contain sufficient information to create an MSP record with an "I" validity indicator, it submits an MSP Inquiry to the COBC, via ECRS (See §10.2). It processes the claim in accordance with its existing claims processing guidelines. This could include, for example, returning the claim to the provider (RTP), pending the claim until the COBC development is complete, or denying the claim. The FI or carrier should not develop for additional MSP information. The COBC performs this development.

B - Self-Reporting/42 CFR 411.25 Development Process

Medicare FIs and carriers are often contacted by various sources that indicate the possibility of primary coverage other than Medicare. These contacts are referred to as "self-reports." Self-reports can cover the full spectrum of MSP situations. For example, the FI or carrier may be contacted related to an accident or illness on behalf of the beneficiary for which auto, no-fault, workers' compensation (including black lung), or other liability insurance may be primary. Similarly, it may receive

notification from an insurer that the FI or carrier has paid a claim for which primary payment of services are the responsibility of a third party payer, pursuant to 42 CFR 411.25. It forwards all such self-reports and notifications under 42 CFR 411.25 to the COBC. The FI or carrier immediately transfers all telephone self-reports and 411.25 notifications to the COBC using the instructions in §10.5. It refers written self-reports and 411.25 notifications to the COBC using ECRS (See §10.2).

C - Trauma Development (TD)

FIs and carriers shall submit information through ECRS to develop for another possible responsible primary payer when they receive information (e.g. correspondence, PIP letter, EOB, etc) that looks like the situation may be related to an accident, injury or illness

The COBC updates CWF based upon the results of the *TD.* Fiscal Intermediaries and carriers must forward to the COBC, within *45* business days of their mailroom date-stamped receipt, trauma code development forms originally sent from the COBC that the FIs or carriers inadvertently received. They should forward the completed *TD* document using the address provided in §10.3.

D **- Value, Condition, and Occurrence Code Development for FIs**

FIs continue to handle all claims containing condition codes under their current guidelines. Effective January 1, 2001, the COBC began receiving an automatic trigger from CWF for claims filed with a condition code of "08" (Beneficiary would not provide Information Concerning Other Insurance Coverage). The COBC develops these claims with the beneficiary. Generally, no additional development is necessary for claims containing MSP condition codes other than "08". However, if a FI receives a claim with condition code 10, 28, 29, D7, and D8, and further development is required, it submits an MSP Inquiry through the ECRS to the COBC.

FIs process claims that are billed "conditionally." An MSP conditional payment is defined as a claim billed with a value code of 12, 13, 14, 15, 16, 41, 42, 43, or 47 with six zeroes (0000.00) entered in the amount field for which the provider is claiming a conditional payment because the other insurance has substantially delayed payment or has denied payment. If there is no MSP record on CWF related to this billing incident, and the FI has sufficient information from the claim submission, it adds an "I" record to CWF. It uses current claims processing guidelines, e.g., RTP, to process claims it receives without applicable necessary fields of information completed.

FIs process claims containing occurrence codes 01-04 and 24 using their current processing guidelines. If there is no MSP record on CWF related to this billing incident, and the FI has sufficient information from the claim submission, it adds an "I" record to CWF. It uses its current claims processing guidelines, e.g., RTP or reject, to process claims it receives without applicable necessary fields of information completed (for example, associated value code, if another payer involved, date of specific event, insurer).

The COBC updates CWF based upon the results of its development. If a FI inadvertently receives a development form originally sent from the COBC, it forwards the form to the COBC within 20 business days of the FI mailroom date-stamped receipt, using the COBC address supplied in §10.3.

E **- Box 10 of the Form CMS-1500 Development for Carriers**

Box 10 on Form CMS-1500 or equivalent electronic media claims when checked indicates that the claims information being submitted may be related to a possible traumatic injury, accident, or illness. *Carriers no longer submit this information via the ECRS for MSP development.* This instruction also applies to MSP information supplied on Forms CMS-1490S and CMS-1491.

For questions it receives on the completion of box 10, the carrier shall refer the inquirer to the COBC Customer Service number provided in *§10.6.*

10.8 - Additional Activities Arranged by Non-GHP MSP Type

(Rev. 1, 10-01-03)

AB-00-107, AB-02-022

Medicare intermediaries and carriers retain the responsibility of handling phone and written inquiries related to existing no-fault insurance (automobile no-fault insurance of all types, including personal injury protection/med-pay), workers' compensation (WC), and liability cases, unless the phone call or written correspondence reveals information discrepant with that on CWF.

The COBC will handle all calls and written correspondence where a beneficiary, third party payer, provider, or attorney is initially reporting the existence of an automobile no-fault, WC, or liability case. The COBC will develop all information necessary to establish a MSP occurrence. These auxiliary records will appear on CWF and the ECRS lead contractor listing within 24 to 48 hours of being established. The COBC will identify and advise the attorney and/or third party payer who the lead contractor is. The COBC will also advise the attorney to forward the lead contractor a signed beneficiary release to establish the case file. The COBC will not maintain any case information, once a lead has been determined. All case documentation received from any source will be forwarded to the lead contractor.

After the COBC has established a new case (i.e., added a "Y" auxiliary record, assigned lead contractor), all follow-up calls are the responsibility of the designated lead contractor.

The following provides additional processing activities based upon specific MSP types, as a result of the initial development for no-fault, workers' compensation, and liability situations. If a termination date or a change related to a no-fault, workers' compensation, or liability situation is reported to the COBC from a source other than

the lead contractor, the COBC will consult by phone with the lead contractor before submitting the termination date or change to CWF.

Fiscal intermediaries and carriers are reminded that they may have overlapping MSP periods for liability, no-fault, workers' compensation, and/or group health plan insurance.

10.8.1 - No-Fault Development

(Rev. 5, 12-22-03)

If Medicare is billed as primary payer, but there is an indication of possible coverage under no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection) the FI or carrier advises the COBC through *the* ECRS. The COBC develops to determine whether there is coverage primary to Medicare through a form of no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection). If there is coverage available, the COBC will post an open "Y" auxiliary record on CWF. Through its initial development *with the insurer and/or attorney*, the COBC will also determine whether the coverage through the no-fault insurance has been exhausted. If benefits have been exhausted, the COBC will post a "Y" record with a termination date indicating the date that coverage was exhausted.

Using the information supplied by the COBC, the FI or carrier processes the claim to payment or denial.

If, after the COBC's initial development, the FI or carrier later determines that benefits have been exhausted under this policy, it may post the termination date following the instructions in §10.1. If it receives information through recovery development efforts that serves to modify the information that is contained on CWF, send a CWF Assistance Request via ECRS (see §10.2) to the COBC.

If upon further investigation the COBC learns that the beneficiary is filing a liability insurance claim, the COBC will apply the termination date and create a new MSP record for the liability situation. If the FI or carrier receives this information, it posts a termination date (if none is existing), and forwards the liability information to the COBC via ECRS.

10.8.2 - Workers' Compensation (WC) Development

(Rev. 1, 10-01-03)

AB-00-107

The COBC develops to determine whether there is coverage primary to Medicare through WC insurance. The COBC determines the nature of the injury using the diagnosis code(s) submitted on the claim and through additional development, as necessary. The MSP auxiliary record added to CWF includes the diagnosis code(s)

relating to that injury. If, after the COBC's initial development, the FI or carrier later determines that benefits have been exhausted under WC, it may post the termination date following the instructions in §10.1. If it receives information through recovery development efforts that serves to modify the information that is contained on CWF, it sends a CWF Assistance Request to the COBC via ECRS (See §10.2).

10.8.3 - Liability Development

(Rev. 1, 10-01-03)

AB-00-107

The COBC develops to determine if a liability (including automobile liability) insurance claim has been or will be filed. If, as a result of that development or receipt of self-reported information (for example, letter from beneficiary or attorney or other beneficiary representative, notification from provider), the beneficiary/representative indicates the intent to file a liability insurance claim, the beneficiary/representative is notified by the COBC of Medicare's potential recovery claim, if there is a settlement, judgment, or award. If an attorney or other beneficiary representative represents the beneficiary, the COBC will, where appropriate, send the attorney or other beneficiary representative a release agreement to be completed and returned directly to the lead contractor. The FI or carrier may post a termination date, following the instructions in §10.1, if it is notified that a liability case has been resolved through a settlement, judgment or award and does not provide for future medical payments. If its recovery development efforts find additional information that serves to modify the information that is contained on CWF, it sends a CWF Assistance Request to the COBC via ECRS (See §10.2).

If the COBC's development indicates there is a possible payment under liability insurance, the FI or carrier shall make conditional payment. The COBC will designate a lead FI or carrier to monitor the progress of the liability claim and coordinate Medicare recovery efforts (See Chapter 7, §50.5).

See §10.8.1 for instructions where a liability insurance claim follows a no-fault situation; FI or carrier is responsible for the same type of actions where a no-fault claim follows a liability claim.

10.9 - COBC Numbers

(Rev. 1, 10-01-03)

AB-00-107

The COBC accretes MSP records using the contractor numbers. Different numbers have been assigned for each COBC activity for purposes of separately capturing savings attributable to each activity. See Chapter 6, §10.2, for a complete list of

COBC numbers and corresponding Nonpayment/Payment Denial codes and Crowd Special Project numbers.

When the FI or carrier submits an "I" record to CWF, its contractor number is shown as the originating contractor. If the COBC converts the record to a "Y" with no change to the information, the originating contractor number remains on the record. If the record is changed to a "Y" and any of the data elements change, one of the COBC's numbers shows as the originating contractor.

20 - Sources That May Identify Other Insurance Coverage

(Rev. 1, 10-01-03)

B3-3328.6, A3-3489.3, B3-4301, A3- 3492.J, B3-3338.2, SNF-337

In the past, FIs and carriers 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 contractor'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 FI or carrier assumes, in the absence of information to the contrary, that this coverage continues.

- Medicare has not made payment and the FI or carrier is asked to endorse a check from another insurer payable to Medicare and some other entity. The FI or carrier 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 FI or carrier 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 FI or carrier 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.

Other insurance that may be primary to Medicare is shown on the UB-92 claim form 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 ICD-9-CM code is shown; or

- Another insurer is shown as the primary payer on line A of item 50.

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 COBC, the FI or carrier uses ECRS to advise the COBC of the possibility of another insurer, and awaits COBC development before processing the claim.

20.1 - Identification of Liability and No-Fault Situations

(Rev. 1, 10-01-03)

B3-3340.4, A3-3418.5, A3-3489, A3-3489.3.A, B3-4305, B3-3338.2.A, B3-4301, HO-262.8, SNF-334, HH-248, AB-00-107

Fiscal intermediaries and carriers must be alert to identify liability and no-fault situations. They can depend on the COBC to do trauma code development that may reveal the existence of liability or no-fault situations. However, contractors must use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability insurer:

- The contractor 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 Medicare carrier or intermediary, 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 contractor or the RO is asked to endorse a check from another insurer payable to Medicare and the beneficiary;

- The contractor 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 contractor 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 intermediary receives an ambulance claim indicating that trauma related services were involved; and

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

In addition, intermediaries use the following indicators on the Form CMS-1450 to identify the possibility of payment by a liability insurer.

- Another insurer is shown as Payer on line A of FL 50 or a primary payer is identified in "Remarks" on the bill;
- Occurrence codes 01 through 03 or 24 are shown in FLs 32-35 or occurrence span code field in FL 36;
- Codes 1 or 2 are shown as the type of admission under FL 19;
- Code 14 is the value code shown under FLs 39-41;
- Condition codes 10, 28, 29, D7, and D8 are shown under FLs 24-30;
- Remarks are in FL 84.

For carriers, completion of block 10 on the Form CMS-1500 indicates another insurer may be involved. The intermediary or carrier 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 "U". This causes CWF to generate an investigation record to the COBC to ascertain the correct MSP period. The COBC 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 intermediary or carrier adjudicates the claim per Chapter 7, §50.4.

20.2 - Identify Claims with Possible WC Coverage

(Rev. 1, 10-01-03)

A3-3409, A3-3409.1, A3-3409.2, B3-3330, B3-3330.1, B3-3330.2, B3-4305

The FI or carrier 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 FI or carrier pays the claim. Such indications may be:

- A denial letter from the WC carrier**;**
- A supplemental statement in remarks on the claim form; or
- For Form CMS-1450 claims an occurrence code 24 (insurance denied) and the date of denial in FLs 28-32.
- For carriers, 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.

Where it appears that the services may be compensatory by WC, the FI or carrier 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 COBC to ascertain the correct MSP period. The COBC 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 FI or carrier adjudicates the claim to a final disposition.

20.3 - Medicare Claims Where Veterans' Affairs (VA) Liability May Be Involved

(Rev. 1, 10-01-03)

B3-4304

Under certain circumstances, the VA may authorize a veteran to receive care on a fee-for-service basis from a non-VA physician/supplier. Generally, this authorization is related to a specific condition. Medicare payment for all other services is appropriate. Since no payment may be made under Medicare for services authorized by the VA, contractors must assure that Medicare funds are not used to supplement or duplicate VA benefits. See the Medicare Benefit Policy Manual, Chapter 17, §50.1, for an explanation of Medicare policy in relation to VA authorized services.

Using information supplied monthly by the VA, the Health Insurance Master File notifies the FI or carrier of possible VA involvement by a "Y" trailer code, code 3, or a code 36, type code 3, automatic notice. The annotation is placed on the record the first month the individual is identified to CMS by the VA and is removed the first month the individual no longer appears on the file furnished by the VA.

20.3.1 - VA Payment Safeguards

(Rev. 1, 10-01-03)

B3-4304.1, B3-4304.2

When the beneficiary is identified as possibly having VA entitlement, the FI or carrier contacts the provider, physician/supplier to determine whether a claim has been, or will be, submitted to the VA for payment for the procedures listed. It does not contact the beneficiary or the VA. It uses only information from the provider,

physician/supplier to determine whether VA liability is involved. It processes the claim according to the following rules:

- If a claim has not, and will not, be filed with the VA, the FI or carrier processes the claim;
- If the provider, physician/supplier responds that the claim is being, or has been, sent to the VA, the FI or carrier denies the claim; and
- If the claim was for multiple services and the physician/supplier states that the VA has assumed responsibility for some, the FI or carrier denies those services and processes the other services.

The FI or carrier establishes a procedure for contacting providers or physicians, suppliers in claims where the VA is indicated.

30 - Develop **Claims** for Medicare Secondary Benefits

(Rev. 1, 10-01-03)

A3-3686

When Medicare is indicated as primary payer on a claim, assume, in the absence of evidence to the contrary, that the provider has correctly determined that there is no other primary coverage and process the claim accordingly. There are instances in which further development is necessary, as discussed in §30.2.

Under the COB contract, effective January 1, 2001, the COBC is responsible for developing whether there is a payer primary to Medicare. The FI or carrier supplies the COBC information via ECRS or by telephone or Fax, depending on circumstances. The FI or carrier obtains the MSP data needed to process claims via CWF, which the COBC updates with the results of its investigations. There is some minimal provision for the FI or carrier to update the MSP auxiliary file on CWF with MSP information. See §10.1, above.

30.1 - **Further Development Is Not Necessary**

(Rev. 1, 10-01-03)

A3-3686.1, Transmittal R1854A3

Medicare providers are required by law to obtain other payer information and to certify that such development has occurred. Submission of the following types of information by a hospital is to be accepted without further inquiry.

- Claim containing a MSP value code and payment amount;
- Condition codes 05, 09, 10, 11, 26, 28, and 29 are shown on the bill;

- Occurrence codes 05, 06, 12, 20, 23, 24, 25, 18, 19, and dates are shown on the bill;
- Use of remarks field for further clarification;
- Claim denied because active MSP record, but claim not filed as MSP;
- MSP claim filed and information on claim matches MSP CWF record; and
- MSP record shows "not active," and claim was filed with Medicare as primary payer.

When such information is submitted, do not attempt further development. The bill automatically updates CWF in the preceding situations. The hospital reviews must ensure that bill submissions are proper and comply with the law's requirements. (See §70.)

In relation to the reporting of occurrence codes 18 and 19, as referenced above, hospitals adhere to the following policy when precise retirement dates cannot be obtained during the intake process:

POLICY: When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, the provider reports the beneficiary's Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, the provider reports the beneficiary's Medicare entitlement date as his or her retirement date.

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it is determined that it has been at least five years since the beneficiary retired, the provider enters the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997, in the format currently used.) As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

30.2 - Further Development Is Required

(Rev. 1, 10-01-03)

The intermediary develops the claim **only** when the following billing situation occurs:

- Condition code 08 is shown on the bill;

- Claim with primary insurer identification, no primary payer amounts, and nothing indicated in remarks field;
- Beneficiary has a black lung CWF record, bill is submitted with a black lung CWF record, and bill is submitted with a black lung diagnosis, but without the primary amount shown or without an Medicare Summary Notice (MSN), or without remarks, which denies the black lung claim;
- MSP claim filed with very low primary payment (investigate for possible keying error with provider to ensure accurate payment amount);
- Trauma diagnosis, no MSP record, and claim does not show occurrence code 05 and date nor remarks;
- Retirement dates same as dates of service (i.e., improper use of occurrence codes 18 and 19);
- Occurrence codes 01-04 used, but not MSP claim. No occurrence code 24 or remarks; and
- No value code and zero dollars showing request for conditional payment.

30.3 - GHP May Be Primary to Medicare

(Rev. 1, 10-01-03)

A3-3491, B3-4302, A3-3686, B3-3328.6, HO-253, SNF-336, HH-253, A3-3492.I

The FI or carrier can process a claim as a claim for secondary Medicare benefits if the claim is accompanied by a primary insurer's MSN that indicates that the insurer has paid in part for services for which Medicare benefits have been claimed. In such a case, the FI or carrier updates CWF with a validity indicator of "I" to add any new MSP occurrences. It must update CWF within 10 calendar days from completion of the evaluation. If the Medicare claim is not accompanied by an MSN, the contractor returns the claim to the claimant with instructions that an MSN from the primary insurer must be submitted for a secondary Medicare claim to be processed.

The FI or carrier obtains the insurer's address and insured's identification from the claimant and forwards it to the COBC via ECRS. It instructs the claimant to file a claim (if this has not already been done) with the primary payer. If a claim has already been filed, the FI or carrier requests a copy of the primary payer's MSN or denial from the claimant and forwards the information to the COBC via ECRS. It does not accept the claimant's allegations about the primary payment.

The contractor considers the possible application of LGHP coverage on benefits when processing claims for items or services furnished on or after August 10, 1993, to beneficiaries for whom Medicare is secondary.

30.3.1 - Limits on Development

(Rev. 1, 10-01-03)

B3-4301.1.D, B-01-33

The FI or carrier checks all claims received according to the date parameters in Chapter 7 to determine if claims already processed should have been paid secondary to Medicare. It recovers any overpayments according to the rules in Chapter 7, "Contractor MSP Recovery Rules."

Where Medicare is indicated as primary payer on the Form CMS-1450, the FI or carrier assumes, in the absence of evidence to the contrary, that there is no other primary coverage and processes the claim accordingly. If CWF indicates that Medicare is secondary, the FI or carrier notifies the COBC via ECRS to develop to determine if there is another payer primary to Medicare.

Where condition code 08 is reported in Items 24-30 of the Form CMS-1450, the contractor returns the claim to the claimant and advises the COBC via ECRS.

30.3.2 - Develop ESRD Claims Where Basis for Medicare Entitlement Changes

(Rev. 1, 10-01-03)

B3-4303

Medicare is the secondary payer throughout the entire 30-month ESRD coordination period. If the beneficiary becomes disabled or aged before the coordination period ends, see Chapter 2, §20.1.3, of this manual. To assist FIs and carriers in processing claims under these provisions, the COBC determines the coordination period based upon information it develops, and updates the CWF (See Chapter 3).

30.4 - Workers' Compensation Responses

(Rev. 1, 10-01-03)

A3-3409.3, A3-3409.9, B3-3330.3, SNF-329.7, HH-250.19

If the COBC investigation indicates that WC benefits could be paid for the services, the FI or carrier denies benefits and notifies the claimant that Medicare benefits are not payable for services covered under WC. It advises the claimant to file for WC, and, if a WC claim is filed and denied, the Medicare claim may be reopened. It further advises the claimant that if the reason for denial of WC benefits is due to the claimant's failure to timely file a claim, Medicare payment will not be made. It documents the determination.

When Medicare benefits are denied because all or part of the services are reimbursable under the BL program, the FI or carrier advises the claimant to submit a claim to:

Federal Black Lung Program
P. O. Box 828
Lanham-Seabrook, MD 20703-0828

The FI or carrier advises the claimant that Medicare cannot pay for the services, because the Federal Black Lung program, administered by DOL, pays primary to Medicare, but, if DOL does not pay for all services, the claimant should resubmit the claim to the FI or carrier with a copy of DOL's explanation of its payment.

30.4.1 - Patient Receives Concurrent Services Which Are Not Work-Related

(Rev. 1, 10-01-03)

B3-3330.4

Sometimes an individual receives services for a condition that is not work-related from the same provider or physician/supplier who is furnishing services for a work-related condition. The diagnosis may indicate a service for a preexisting condition or the provider or physician/supplier may submit a separate bill for services indicating that the service is for a non-work-related condition. Where it is clear that services for a non-work-related condition were rendered, the FI or carrier does not delay payment for such services even though payment for the work-related services is being denied or delayed pending development under the WC exclusion.

30.5 - No-Fault Responses

(Rev. 1, 10-01-03)

A3-3489.3B

The COBC conducts all no-fault investigations (See Chapter 3 and §10.8.1, above). If Medicare is billed as primary payer, but the COBC indicates there is coverage under no-fault insurance and the provider did not submit a satisfactory explanation to the development request concerning why Medicare is billed as primary, the FI or carrier denies the claim.

30.5.1 - No-Fault Insurer Denies That It Is the Primary Payer

(Rev. 1, 10-01-03)

B3-3338.4

Denial by an insurer on the basis that Medicare is primary payer may be a forerunner of similar action on multiple claims. Advise the COBC of this circumstance via ECRS. The COBC is responsible for any needed action with the no-fault insurer.

30.5.2 - No-Fault Insurance Does Not Pay All Charges Because of a Deductible or Coinsurance Provision in Policy

(Rev. 1, 10-01-03)

B3-3338.5, A3-3489.4, HO-262.12, SNF-334.4, HH-248.4

In a number of States, no-fault insurers may reduce no-fault insurance benefits by deductible or coinsurance amounts, or may offer the option for such a reduction. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such a no-fault contract. Therefore, if a no-fault insurer has been billed and has made no payment because of a deductible or coinsurance, or only a partial payment (e.g., the insurance deductible has been bridged), Medicare may pay but, before payment is made, require an MSN or similar notice issued by the no-fault insurer showing the status of the no-fault insurance deductible after taking into account the expenses for which Medicare is being billed.

EXAMPLE 1

A beneficiary receives physician services covered by no-fault insurance. Total charges are $200. The no-fault insurer is billed but makes no payment because of a $1000 deductible in the policy. The provider on behalf of the beneficiary submits a claim for $200 to Medicare along with a copy of explanation of benefits from the no-fault insurer. Medicare can pay benefits on this claim in the usual manner.

EXAMPLE 2

Beneficiary's operation is covered by no-fault insurance, which allows physician's full charges of $1640, but pays only $756 because it reduces payment by an $800 unmet deductible under the no-fault policy, as well as by $84 coinsurance. The physician bills Medicare for $884. If the physician did not submit a copy of the no-fault insurer's explanation of benefits, request it. The Medicare reasonable charge for the services is $1200. The beneficiary has not previously met the Medicare deductible for that year. Calculate the payment as noted below.

A. Determine Medicare payment in the usual manner:

$1200 reasonable charge - $100.00 deductible = $1100 x 80% = $880

B. Determine the higher of the Medicare reasonable charge or no-fault allowable charge:

No-fault allowable charges = $1640

Medicare reasonable charge = $1200.

C. Subtract the primary insurance payment from the no-fault allowable charge:

$1640 - $756 = $884

Medicare pays $884

30.5.3 - State Law or Contract Provides That No-Fault Insurance Is Secondary to Other Insurance

(Rev. 1, 10-01-03)

B3-3338.6, A3-3489.5, HO-262.12, HO-262.13, SNF-334.4, SNF-334.5, HH-248.4 HH-248.5

Even though State laws or insurance contracts specify that benefits paid under their provisions are secondary to any other source of payment or otherwise limits portions of their benefits to payments only when all other sources of health insurance are exhausted, Medicare does not make payment when benefits are otherwise available. For example, a state provides $2,000 in no-fault benefits for medical expenses and an additional $6,000 in no-fault benefits are available, but only after the claimant has exhausted all other health insurance. In such cases, the Medicare law has precedence over state laws and private contracts. Therefore, Medicare makes secondary payments only after the total no-fault benefits are exhausted.

30.6 - Liability Claim Is Filed and There is Also Coverage Under Automobile or Non-Automobile Medical or No-Fault Insurance

(Rev. 1, 10-01-03)

B3-3338.7, A3-3489.6, B3-3340.7

If injuries are covered under automobile medical or no-fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, a claim determination must first be made by the automobile medical or no-fault insurer before a claim for Medicare benefits can be paid. This determination should be made to prevent Medicare from paying primary. Medicare payments may be made to the extent that payment cannot be made under the automobile medical and no-fault insurance, subject to recovery if the individual later receives payment from a

liability insurer. The COBC undertakes the necessary development and updates the CWF.

For example, an individual incurs $20,000 in hospital expenses due to an automobile accident. The individual receives $5,000 in no-fault insurance benefits toward hospital expenses and has a liability claim pending. Medicare will not pay benefits for the $5,000 in expenses paid for by the no-fault insurer, but will pay the remaining $15,000 for the entire hospital stay, if the liability insurer does not pay promptly, subject to recovery when the liability claim is paid.

30.7 - Beneficiary Refuses to Provide Requested Information

(Rev. 1, 10-01-03)

A3-3686, B3-3328.7

Where the beneficiary refuses to provide an intermediary with requested information, deny the claim and notify the beneficiary accordingly. When denying claims for inpatient services, utilization is chargeable. Therefore, intermediaries report a nonpayment code R in the CWF record.

If the beneficiary does not furnish the carrier information needed to determine if another payer is primary to Medicare or to determine the amount of the other payer's primary payment, deny the claim for lack of sufficient information. Also see §60 below for criteria that must be met in order to count any amounts from such claims as MSP savings on the Form CMS-1564.

30.8 - Audit Trail of Primary Coverage

(Rev. 1, 10-01-03)

A3-3491.5, A3-3490.3, HO-263.3, HO-264.7, SNF-335.7, SNF-336.6, HH-252.7, HH-253.6

When processing a claim for secondary benefits for services furnished an individual who has insurance primary to Medicare, the contractor must search its records for any claims paid with Medicare primary benefits for services provided within the time limit stipulated, and which have not been annotated to indicate a valid prior GHP denial which would apply to subsequent claims. See Chapter 7, "Contractor Recovery Rules."

40 - FI and Carrier Claim Processing Rules

(Rev. 14, 04-09-04)

MSP PRE-PAY ACTIVITIES – (ACTIVITY CODE 22001)

No workload or cost associated to initial claims entry should be charged to the MSP Activity Code 22001. ***Bill payment activities must be reported to the Program Management Activity Code 11001.***

There are two steps to keying the secondary claim in its entirety. The first step covers the keying of the claim as received, not including the attached Explanation of Benefits (EOB)/ Remittance Advice (RA). The second step covers the keying of data from the EOB/RA to prepare the claim for entry into claims adjudication and calculation of the Medicare secondary payment at the claim or service line level by the MSPPAY module.

I. Listed below are initial claim entry activities that should not be charged to MSP Activity Code 22001.

- *Receipt, control of claims and attached EOB/RA. Includes open, sort, date stamp, image, Control Number assignment, Optical Character Reader process, batching claims and activation of batches.*

- *Preparation of batches for keying. Includes verification that all batches are accounted for and claims are in proper order within the batch.*

- *Keying the entire MSP claim into the standard system to begin claims processing.*

- *Resolution of all claim entry edits.*

II. Keying payment information from the primary payer's EOB/RA as part of the hard copy claim should not be charged to MSP Activity Code 22001. The keying of the EOB/RA brings the hard copy MSP claim to the same status as the receipt of an MSP Electronic Media Claim and preparing the claim for adjudication. The primary payment information is crucial in determining the appropriate amount Medicare should pay as the secondary payer, an amount calculated within the MSPPAY module during claim adjudication.

The following list includes primary payer information that may be present on the EOB/RA or may need to be determined, then keyed, to complete entry of the hard copy claim into the standard system. All costs associated to these functions should be charged to Activity Code 11001.

NOTE: *Individual EOB/RAs may use different but similar terms.*

Actual Charges

Provider Discount

Contract Write-off

Primary Payer Allowed Amount

Primary Payer Paid Amount

Obligated to Accept as Payment in Full

Deductible

Co-pay/Co-Insurance

Non-covered Services

Benefits Paid

Covered Charges

Withhold

40.1 - Claim Indicates Medicare is the Primary Payer

(Rev. 1, 10-01-03)

B3-3328.7, A3-3490.3, A3-IM-3491

Where the claimant indicates Medicare is the primary payer, the FI or carrier assumes, in the absence of evidence to the contrary, that the claimant has correctly determined that there is no primary GHP coverage and processes the claim. It pays primary Medicare benefits only if the services were not rendered during a coordination period, or if the GHP denies a claim because the beneficiary is not entitled to benefits under the plan, or benefits under the plan are exhausted for the particular services, or the services are not covered by the GHP, and the beneficiary is not appealing the GHP denial. The FI or carrier does not pay primary benefits if there is reason to believe that the GHP covers the services. If the FI or carrier pays primary Medicare benefits and later learns that the beneficiary is appealing the GHP denial, it treats the payment as a conditional primary payment and initiates appropriate recovery actions.

If an intermediary believes that a GHP may be the primary payer, the FI returns the bill to the provider requesting the provider to ascertain whether primary GHP benefits are payable, and if so, to bill for primary benefits. The FI should instruct the provider that if a GHP has denied its claim for primary benefits, the provider must annotate the claim with the reason for the denial and enter occurrence code 24 and the date of denial. No attachment is needed.

When a claim is received from a member of a religious order who has taken a vow of poverty, whose order filed an election under §3121(r) of the IRC, and who does not have group health coverage from employment outside the order, the FI or carrier processes the claim as a primary Medicare claim.

A GHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on Medicare. The FI or carrier evaluates claims under existing guidelines to assure that Medicare covers the services, regardless of the GHP decision.

40.1.1 - Facts Indicate Reasonable Likelihood of Workers' Compensation Coverage (Other Than Federal Black Lung Benefits)

(Rev. 1, 10-01-03)

B3-3330.5, A3-3409.4

If the submitted claim or the CWF response indicates WC (excluding Black Lung) is responsible, the FI or carrier denies the claim.

The notice to the provider or physician/supplier and beneficiary should:

- State that the services are not covered under Medicare because the law prohibits payment for services which are reimbursable under a WC law or plan;
- Advise the beneficiary, provider or physician/supplier to submit a claim to the beneficiary's WC carrier (or employer if the employer is self-insured) and;
- Inform the provider or physician/supplier that if the WC carrier does not pay for all of the services, the provider or physician/supplier should resubmit the claim to Medicare for further consideration with a copy of any notification received from the WC carrier explaining why the services are not reimbursable under WC.

If it is not clear whether WC is responsible, the FI or carrier advises the COBC of possible WC involvement and adjudicates the claim based on the results of the COBC's development.

40.1.1.1 - The Beneficiary Is on the Black Lung Entitlement Rolls

(Rev. 1, 10-01-03)

B3-3330.6A, A3-3409.5

If a FI or carrier learns that the beneficiary may be entitled to receive medical benefits from the Department of Labor (DOL) under the Federal Black Lung Program, it advises the COBC of possible Federal Black Lung Program involvement and adjudicates the claim based on the results of the COBC's development.

40.1.2 - Services by Outside Sources Not Covered

(Rev. 1, 10-01-03)

A3-3490.16.A, A3-3491.17.A, B3-3329.4.A, HO-263.17, HO-264.17, SNF-335.17, SNF-336.17, HH-253.16, HH-252.17, B3-3329.13, B3-3329.4

Where Medicare is secondary payer for a person enrolled in an employer sponsored managed care health plan (e.g., Health Maintenance Organization (HMO)/Competitive Medicare Plan (CMP)), Medicare does not pay for services obtained from a source outside the employer-sponsored managed care health plan if:

- The same type of services could have been obtained as covered services through, or paid for by, the managed care employer health plan, or
- The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the managed care health plan's service area, e.g., while the individual is away from home.

At the time of admission, providers are to ask beneficiaries that are enrolled in GHPs whether the plan is a managed care health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required to be sent to intermediaries per Chapter 3, §40.1.)

NOTE: This restriction only affects Medicare beneficiaries enrolled in employer sponsored managed care health plans that either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/CMP are locked into the plan in all instances except for emergency or urgently needed services.

40.1.2.1 - Exception

(Rev. 1, 10-01-03)

A3-3490.16.B, A3-3491.17.B, B3-3329.4.B, HO-263.17, HO-264.17, SNF-335.17, SNF-336.17, HH-252.17, HH-253.16, B3-3329.4B

If a beneficiary obtains services from a source outside the managed care GHP, and has not been notified in writing of this special rule, Medicare pays, provided the plan will not pay for legitimate reasons. In general, it is assumed that written notification has not been given in the absence of evidence to the contrary, e.g., the contractor’s internal system indicates that the beneficiary is a working aged, ESRD, or disabled beneficiary who belongs to a managed care GHP and that the beneficiary has been notified that Medicare will not pay. Where payment is made for services from a source outside the managed

care health plan, the Medicare Benefits Notice (Form CMS-1533), or the MSN, where applicable, states the following:

> Our records show that you are a member of an employer sponsored managed care health plan. Since Medicare is secondary payer for you, services from sources outside your health plan are not covered. However, since you were not previously notified of this, we will pay this time. In the future, payment will not be made for non-plan services that could have been obtained from or through the prepaid health plan.

40.1.3 - Notice to Beneficiary

(Rev. 1, 10-01-03)

A3-3490.16.C, A3-3491.17.C, B3-3329.4.C, HO-263.17, HO-264.17, SNF-335.17, SNF-336.17, HH-252.17, HH-253.16

The FI or carrier denies any bills received for Medicare payment from, or on behalf of a beneficiary enrolled in a managed care GHP who has previously been notified in writing. Advise that the reason for the denial is that Medicare's records show that the beneficiary is a member of a managed care health plan as follows:

> Our records show that you are a member of an employer sponsored managed care health plan. Because Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from or through the managed care health plan are not payable. Medicare's records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received.

(There are standard Medicare Summary Messages (MSN) that convey this information.)

40.2 - Update CWF MSP Auxiliary File

(Rev. 1, 10-01-03)

A3- 3490.16.D, A3-3491.17.D, B3-3329.4.D, HO-264.17, SNF-335.17, HH-252.17, B3-3329.4

When a contractor has identified a beneficiary under §40.1.3 and either the contractor has notified the beneficiary in writing that Medicare does not pay for services obtained outside of the plan or there is information that the beneficiary was previously notified, the FI or carrier must update their internal system to show that the beneficiary is a working aged, ESRD, or disabled beneficiary who belongs to a managed care GHP and that the beneficiary has been notified that Medicare will not pay. This is accomplished by entering the following information in remarks:

"Working aged, ESRD, or disabled beneficiary belongs to a managed care GHP. Medicare will not pay".

40.2.1 - Action if Payment Has Been Made Under No-Fault Insurance

(Rev. 1, 10-01-03)

B3-3338.2.C.1, HO-263.17, SNF-336.17, HH-253.16

If the FI or carrier is aware when processing a Medicare claim that payment has been made either to the provider, physician, or to the beneficiary under no-fault insurance, the FI or carrier denies the claim. However, Medicare secondary payments can be made if the no-fault insurer paid less than the full physician's charge **and** the physician is not obligated to accept the payment as payment in full. If contractors learn after Medicare benefits were paid, that payment was also made by a no-fault insurer, the excess Medicare benefits are subject to recovery in accordance with the Medicare Financial Management Manual, Chapter 3, §20. Chapter 7, §40.2.2, states when a physician is liable for refunding the primary Medicare payments. The beneficiary is liable in all other situations.

40.3 – Processing Part B Claims Involving GHPs

(Rev. 1, 10-01-03)

B3-3328.7

When it appears that a GHP should be primary payer, a claim for Medicare primary benefits may not be processed unless accompanied by an explanation of benefits from the insurer indicating that the GHP has previously processed a claim for the services and denied primary benefits for reasons other than it makes payment after Medicare for services provided to the beneficiary.

If the claim is not accompanied by a GHP's explanation of benefits, the FI or carrier asks the claimant to provide one.

Unless the claimant submits a satisfactory explanation (preferably a copy of the GHP's notice) of why full or partial payment under primary insurance cannot be made, or in WC, liability, or no-fault claims, there is evidence that a decision will not be made promptly, the FI or carrier denies the claim for primary Medicare benefits. Medicare is primary only if an insurer that is primary to Medicare cannot make payment. Examples of acceptable reasons why the GHP cannot pay are:

- A deductible applies, or
- The beneficiary is not entitled to benefits, or
- Benefits under the plan are exhausted for particular services, or

- The services are not covered under the plan.

However, the primary insurer **cannot** assert that the beneficiary is not entitled to **primary** benefits or the services are not covered for **primary** payment under the plan.

If the FI or carrier pays primary benefits and later learns that the beneficiary is appealing the GHP's denial, it treats the payment as a conditional primary payment. When a primary Medicare claim is denied, the denial notice informs the claimant that, after the primary insurer has processed the claim for primary benefits, a claim for secondary Medicare benefits may be filed and that a copy of the GHP's explanation of benefits must be included.

40.3.1 - GHP Denies Payment for Primary Benefits

(Rev. 1, 10-01-03)

B3-3328.4, A3-3491.9, A3-3490.3.D, B3-3328.C.1, A3-3490.3.F, B3-3328.5, HO-263.10, SNF-336.10, HH-253.10

Where a GHP has denied the claim because the plan provides only secondary coverage, the FI or carrier denies the claim for Medicare primary benefits. If a provider bills a GHP and the plan refuses to pay primary benefits because it claims that its benefits are secondary to Medicare's, the FI or carrier does not pay conditional benefits. It denies the claim and refers the case to the COBC.

If the FI or carrier pays primary Medicare benefits and later learns that the beneficiary is appealing the GHP denial, it treats the payment as a conditional primary payment and seeks recovery in accordance with Medicare guidelines.

An intermediary should instruct its provider that, if a GHP has denied its claim for primary benefits, the provider must annotate Item 84 "Remarks" of the Medicare claim form with the reason for the denial and enter occurrence code 24 and the date of denial in Items 32 to 35. The intermediary annotates its records with the reason for the denial to avoid needless recovery efforts.

The carrier processing a claim with similar GHP involvement would send the beneficiary a denial letter including similar information and state that if the GHP does not pay the full charge, then the beneficiary must submit a claim for secondary benefits including a copy of the GHP's explanation of benefits. If the physician, or supplier accepted assignment, the carrier notifies the physician/supplier and the beneficiary that the beneficiary may not be charged more than the Medicare deductible and coinsurance amounts and charges for noncovered services. (Services that are or could have been paid for by the GHP are not considered "noncovered.")

Any denial notice must include appropriate appeals information. The carrier advises the beneficiary to consult with his or her employer and/or the state insurance commissioner or other official having jurisdiction (such as the U.S. Department of Labor) if he or she believes the GHP should have paid for the services. The FI or carrier also advises the

claimant of the private right of legal action to collect double damages. (See Chapter 2, §40.1.)

40.3.2 - GHP Does Not Pay Because of Deductible or Coinsurance Provision

(Rev. 1, 10-01-03)

B3-3328.8

A GHP may reduce benefits by deductible and coinsurance amounts. If such provisions apply to all policyholders, Medicare pays secondary benefits with respect to Medicare covered expenses that are not reimbursable under the GHP contract. Therefore, if a GHP has been billed and has made no payment or only partial payment because of a deductible or coinsurance, Medicare may pay. Before paying such a claim, the FI or carrier requires an explanation of benefits or similar notice issued by the GHP showing the status of the deductible after taking into account the expenses for which Medicare is being billed.

40.3.3 - GHP Gives Medicare Beneficiary Choice of Using Preferred Provider

(Rev. 1, 10-01-03)

B3-3328.9

If a Medicare beneficiary is given the choice by the GHP whether to choose a preferred provider or to obtain medical services from a non-preferred provider, the beneficiary may choose the non-preferred provider and Medicare makes secondary payments based on the amount paid by the GHP. However, see Chapter 1 for rules governing employer-sponsored HMO/CMPs when Medicare cannot make primary payments.

40.4 - GHP Pays Primary

(Rev. 1, 10-01-03)

B3-3328.2

40.4.1 - GHP Pays Charges in Full

(Rev. 1, 10-01-03)

B3-3328.2, A3-3490.8

If the GHP pays the provider's, physician's, or supplier's charges in full, the provider, physician, or supplier is obligated to accept, or the provider, physician, supplier voluntarily accepts, the GHP's approved amount as full payment, the FI or carrier does not make any Medicare payment. (Physicians and other suppliers that participate in Blue Shield plans or HMO/PPO arrangements typically must accept the Blue Shield plan’s or HMO/PPO arrangement’s approved amount as payment in full.)

Any excess of the GHP's payment over the gross amount payable by Medicare is not subtracted from the provider's Medicare reimbursement. The provider submits a no payment bill in accordance with Chapter 3 – MSP Provider Billing Requirements, §40.1.

40.4.2 - GHP Pays Portion of Charges

(Rev. 1, 10-01-03)

B3-3328.3, A3-3490.7

Medicare secondary payment can be made if the following conditions are met:

- A GHP pays an amount less than the physician's/supplier's charges for the services, and less than the gross amount payable by Medicare (as defined below),

and;

- the provider does not accept, and is not obligated to accept, the payment as payment in full.

"Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation."

40.4.3 - GHP Pays Primary Benefits When Not Required

(Rev. 1, 10-01-03)

B3-3328.16, A3-3490.13, 3491.15

Cases may come to the contractor's attention in which a GHP has mistakenly paid primary benefits for the services of a physician/supplier (e.g., the GHP of an employer of less than 20 employees has paid primary benefits). If the time limits for reopening in the Medicare Contractor, Beneficiary, and Provider Communications Manual, Chapter 1, §§50.25, permit, and if requested by the physician/supplier or beneficiary, the FI or carrier reopens the Medicare secondary claim, pays any additional amount due as primary benefits, and notifies the GHP of any such Medicare payments. If the Medicare carrier receives a secondary claim on an assignment basis, it pays the additional amount to the physician/supplier. It instructs the provider or physician/supplier to refund to the GHP or the beneficiary the amount that the GHP or the beneficiary has paid in excess of the applicable Medicare deductible and coinsurance and charges for noncovered services. If the Medicare carrier received the secondary claim on an unassigned basis, it pays the additional amount to the beneficiary and advises the beneficiary to make appropriate refund to the GHP. However, Medicare cannot require the beneficiary to make this refund even though the beneficiary may be legally obligated to repay the GHP.

When a GHP has mistakenly paid primary benefits for the services of a physician/supplier and no Medicare claim was submitted for those services, it is the responsibility of the physician/supplier to submit an assigned or unassigned Medicare claim, as appropriate. (The time limit on filing may be extended if failure to file timely resulted from error or misrepresentation by an employee, intermediary, carrier, or agent of the DHHS. For this purpose, the Social Security Administration is considered an agent of the DHHS.)

In such cases where a GHP has inappropriately paid primary benefits, intermediaries instruct the provider to bill Medicare as primary payer and to refund to the GHP the amount it paid, except for an amount equivalent to the Medicare deductible and coinsurance amounts, and charges for noncovered services.

40.5 - Primary Payer Is Bankrupt or Insolvent

(Rev. 1, 10-01-03)

B3-3328.14

When a primary payer fails to pay primary benefits in accordance with CMS' policy because it is bankrupt or insolvent, CMS does not make a conditional primary payment and does not make a Medicare secondary payment until after the conclusion of the bankruptcy or insolvency proceedings.

After the conclusion of the bankruptcy or insolvency proceedings, providers, physicians, or other suppliers may file Medicare secondary claims. The CMS determines the amount of Medicare secondary payments, if any, after the conclusion of the bankruptcy or insolvency proceedings.

40.5.1 - Billing Beneficiaries During the Liquidation Process

(Rev. 1, 10-01-03)

B3-3328.14.B

During the liquidation process, participating providers, physicians, and other suppliers who have accepted assignment may not collect or seek to collect from the beneficiary or the beneficiary's estate, charges for Medicare covered services. Under the terms of the Medicare provider agreement and the terms of the Medicare assignment, the providers, physicians, and other suppliers may bill the beneficiary (or the beneficiary's estate) only to establish a legal claim for future collection of charges and not for purposes of currently collecting charges from the beneficiary or the beneficiary's estate.

40.5.2 - When to Make a Medicare Secondary Payment

(Rev. 1, 10-01-03)

B3-3328.14.C

After the conclusion of the bankruptcy or insolvency proceedings, Medicare secondary payments may be made if the:

- Provider or physician/supplier has filed a claim with the receiver (i.e., the entity responsible for settling and/or paying the outstanding debts of the bankrupt or insolvent primary payer);

- Payment made on behalf of the bankrupt or insolvent entity responsible for paying primary benefits is less than the amount of the charge and less than the amount Medicare would have paid as the primary payer; and

- Provider, physician, or other supplier is not required to accept the payment as full discharge of the liability of the beneficiary (or estate) for the bill.

The receiver determines the payments that can be made on behalf of the bankrupt or insolvent entity. The providers, physicians, and other suppliers receive any available primary payment from the receiver and can then file Medicare claims to obtain any appropriate secondary payments. After the Medicare secondary claims have been processed, any remaining liability (e.g., deductibles, coinsurance, and payment for noncovered services) of the beneficiary (or of a deceased beneficiary's estate) can be pursued by the providers, physicians, and other suppliers. However, they may not pursue collection from the beneficiary if a receiver orders that the allocated fractional payment must be accepted as full discharge of the entire bill.

If circumstances dictate, CMS will advise FIs and carriers by a Program Memorandum that it will coordinate the pursuit of the bankruptcy court's findings and communicate the results to them.

40.5.3 - Amount of Secondary Payment

(Rev. 1, 10-01-03)

B3-3328.14.D

The amount of the Medicare secondary payment is computed based on the amount of the primary payer's liability, as determined by the receiver, and the terms of the payments made by the receiver on behalf of the primary payer.

If the receiver determines that the provider or physician/supplier may pursue collection of the portion of the charge not paid by the receiver, a Medicare secondary payment may be made. The Medicare secondary payment is computed based on the amount the receiver pays on behalf of the bankrupt or insolvent entity (i.e., the amount paid by the receiver

constitutes the primary payment on which Medicare bases its secondary payment). In effect, this means that the Medicare secondary payment makes up for the liability of the primary payer that was not satisfied because of lack of funds.

EXAMPLE

A participating physician furnishes a service for which the approved charges of the primary payer and Medicare are $100 and $90, respectively. The primary payer would normally pay 80 percent of $100, or $80, and Medicare would make a secondary payment of $100 minus $80, or $20. However, the primary payer is bankrupt and, after a long delay, its receiver pays the physician only $32. Medicare pays the physician $100 minus $32, or $68, which is $48 more than its normal liability (i.e., $68 minus $20).

If the receiver determines that the fractional payment must be accepted as full discharge of the amount the primary payer would have been obligated to pay were it not bankrupt or insolvent, the Medicare secondary payment amount would be the amount payable had the receiver paid the full primary payment (i.e., Medicare pays only $100 minus $80, or $20).

If the receiver determines that the provider and physician or other supplier is required to accept the fractional payment as full discharge of the entire bill, Medicare may not make a secondary payment. Thus, in the above example, the receiver might determine that the physician must accept the $32 it pays as payment. In the above example, the receiver might determine that the $32 it pays fully discharges the liability of the primary payer for the $80 the primary payer would have paid if it were solvent (i.e., in this situation, the full discharge of the physician's bill). In this case, Medicare makes no secondary payment.

40.5.4 - Time Limits for Filing Secondary Claims After Liquidation Process

(Rev. 1, 10-01-03)

B3-3328.14.E

Participating providers and physicians and other suppliers that have accepted assignment should file claims with a receiver as soon as possible. The time limit for filing secondary claims once the liquidation process has been completed is the later of the following:

- The usual time limit specified in regulations for filing Medicare claims (i.e., on or before December 31 of the calendar year following the year in which the services were furnished if the services were furnished during the first nine months of a calendar year or on or before December 31 of the second calendar year following the year in which the services were furnished if the services were furnished during the last three months of the calendar year (see 42 CFR 424.44(a)); or

- The last day of the sixth month following the month of the written notice by the bankrupt or insolvent entity to the provider, physician, or other supplier of the amount of primary benefits payable.

When the contractor denies a claim for Medicare conditional primary or secondary benefits in insolvency cases because the receiver has not completed the determination of final payment, notify the provider or physician/supplier of the possible 6-month extension on filing claims as described above.

40.6 - Conditional Primary Medicare Benefits

(Rev. 1, 10-01-03)

A3-3490.3.E, A3-3682.5.B, A3-3682.5.E, A3-3682.5.G

Conditional primary Medicare benefits may be paid if;

- The beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare;

- The GHP denied the claim because the time limit for filing the claim with the GHP has expired (whether appealed or not);

- The provider has filed a proper claim under the employer plan, and the plan denies the claim in whole or in part;

- The provider fails to file a proper claim because of mental or physical incapacity of the beneficiary;

- The beneficiary has filed a claim with a WC carrier and the FI or carrier determines that the WC carrier does not pay promptly (i.e., within 120 days of receipt of the claim) for any reason except when the WC carrier claims that its benefits are only secondary to Medicare; or

- The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement of the WC carrier.

Before making a conditional primary payment in cases involving appealed or protested claims, the FI or carrier notifies the GHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for reimbursing Medicare up to the amount it has paid, if the GHP subsequently approves the claim. In addition, the FI or carrier notifies the GHP that if it pays the beneficiary, it is still liable to reimburse Medicare for the amount Medicare paid conditionally (up to the GHP primary payment). (However, failure to notify the parties does not relieve them of the obligation to refund the payment.) The FI or carrier follows up periodically with the insurer to determine the outcome of the disputed claim. If the GHP allows the claim, the FI or carrier recovers the Medicare payment directly from the GHP. (See Chapter 7.) Where a GHP has denied payment because its claim-filing deadline has expired, **Medicare must honor the GHP claim filing deadline rules.**

40.6.1 - Conditional Medicare Payment

(Rev. 1, 10-01-03)

A3-3407.6.B, B3-3338.3, B3-2370.6, A3-3682

There is frequently a long delay between an injury and the decision by a State WC agency, no-fault, or liability insurer in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either WC, no-fault or liability insurer or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made. They are conditioned upon reimbursement to the trust fund if it is determined that the services are covered by a GHP.

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that the insurer subsequently makes payment. When making such payments, the FI or carrier notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.) It asks the insurer to notify it when the insurer is prepared to pay the claim, so that direct refund can be arranged.

FIs and carriers flag all cases for possible follow-up action to recover the conditional payments. Providers of service request conditional payments from FIs via the Form CMS-1450 using the appropriate insurance value code (i.e., value code 14 for no-fault insurance) and zero as the value amount.

Type of Insurance	**Value Code**	**Value Amount**	**Occurrence Code**	**Condition Code**
No-Fault/Liability	14	0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date	
WC	15	0	04-Accident/Tort Liability & Date	02-Condition is Employment Related
ESRD	13	0	24-Date Insurance Denied	
GHP	12 or 43	0	24-Date Insurance Denied	

The identity of the other payer is shown on line A of item 50, the identifying information about the insured is shown on line A of items 56-62 and the address of the insured is shown in item 38 or Remarks (Item 84). Fiscal Intermediaries and carriers process conditional payment bills following normal procedures.

40.6.2 - When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable

(Rev. 1, 10-01-03)

A3-3490.3.F, A3-3489.8, B3-3338.3, A3-3682.5.D, A3-3682.5.E, A3-3682.5.G, HO-262.14, SNF-334.6, HH-248.6

Neither primary nor conditional primary Medicare payments may be made where a GHP denies payment for particular services because:

- The services are not covered by the plan, and there is reason to believe the plan does cover the services;
- The plan offers only secondary coverage of services covered by Medicare. Conditional primary benefits may not be paid in this situation even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, the FI or carrier denied the claim for Medicare primary benefits and follows the instructions in §10.7;
- The plan limits its payments when the individual is entitled to Medicare;
- The services are covered under the EGHP for younger employees and spouses but not for employees and spouses age 65 or over;
- The provider fails to file a proper claim for any reason other than the physical or mental incapacity of the beneficiary; or,
- When the employer plan fails to furnish information that is requested by CMS and that is necessary to determine whether the employer plan is primary to Medicare.

Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider or the beneficiary failed to file a proper claim. (See Chapter 1, §20, for definition.) Exception: When failure to file a proper claim is due to mental or physical incapacity of the beneficiary, and the provider could not have known that a no-fault claim was involved, this rule does not apply.

40.6.3 - Conditional Primary Payment in Cases Involving a Denied Claim That Was Appealed

(Rev. 1, 10-01-03)

B3-3328.C.1

Before making a conditional primary payment in cases involving a denied claim that was appealed, the FI or carrier notifies the GHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for

reimbursing the program up to the amount the GHP has paid if it subsequently approves the claim. It follows up periodically with the insurer to determine the outcome of the disputed claim. If the GHP allows the claim, the FI or carrier recovers the Medicare payment directly from the GHP.

40.7 - Carrier Processing Procedures for Medicare Secondary Claims

(Rev. 1, 10-01-03)

B3-4301.1

A - Validity Edits

Carriers are responsible for validating the data submitted on Medicare claims including MSP data.

Carriers use the date of birth in CWF records to determine the month and year of birth. When the patient is the spouse of the worker, the carrier obtains the date of birth of both the worker and the spouse. The carrier presumes that the day of birth is not the first of the month unless information on the claim form indicates that it is. A person is considered 65 or 70 for the month if he "attains" 65 or 70 any time during the month. For Medicare entitlement purposes, a person attains a particular age on the day before his or her birthday. Therefore, if a person's 65th birthday is on the first day of a month, Medicare is secondary payer beginning with the first day of the preceding month.

B - Verify Part A entitlement

For purposes of reviewing working aged claims, the carrier presumes that Part A entitlement exists for all Medicare beneficiaries between 65 and 69 except those with Health Insurance Claim Numbers ending in "M."

C - Determine if Group Health Plan Coverage Exists

Chapter 1 contains a complete discussion of "employer" and "employer group health plan." The COBC is now responsible for developing whether Group Health Plan (GHP) coverage exists. If the carrier becomes aware that GHP is involved in a claim, for example, through receipt of a claim for secondary benefits with an EOB, and this is not reflected in the CWF response for the claim, the carrier updates the CWF auxiliary file with an "I" indicator to add the new MSP occurrence (see §10.1, subsection 2).

40.7.1 - Crediting the Part B Deductible

(Rev. 1, 10-01-03)

Expenses paid by the GHP count toward the Medicare deductible. For claims where reasonable charge applies, the carrier credits the payment made under the insurer's plan toward the Medicare deductible up to the amount of the Medicare reasonable charge or fee amount for the service, i.e., if the primary plan paid $75 on a procedure and the reasonable charge or fee amount for the procedure is $50, the carrier credits $50 toward the deductible.

The carrier processes all claims to CWF, including those to be denied because the claim has not been submitted to the primary payer, if the Medicare deductible is unmet. If the beneficiary has GHP, and it is not reflected in the CWF response, the carrier either updates the MSP auxiliary file with an "I" indicator if it is sure of the MSP involvement (see §10.1 subsection 2), or if further development is required, advises the COBC via ECRS, and pends the claim awaiting the COBC results via CWF (See §10.2.1, above).

40.7.2 - Medicare Payment Calculation Methodology

(Rev. 1, 10-01-03)

B3-4301.1, B3-3328.20

40.7.3 - Medicare Secondary Payment Calculation Methodology for Services Reimbursed on Reasonable Charge or Other Basis Under Part B

(Rev. 1, 10-01-03)

B3-3328.20.A

When a proper claim has been filed (i.e., a claim that is filed in a timely manner and meets all other filing requirements of the GHP), the amount of secondary benefits payable is the lowest of the:

- Actual charge by the physician/supplier (or the amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the GHP;

- Amount Medicare would pay if services were not covered by a GHP. (In determining this amount, the payment limitations in the Medicare Benefit Policy Manual, Chapter 16, §50 and 50.1, for non-inpatient psychiatric services apply; and the payment limitations in the Medicare Benefit Policy Manual, Chapter 15, §60, for physical therapy services apply.); or

- Higher of the Medicare fee schedule or other amount that would be payable under Medicare (without regard to any Medicare deductible and/or coinsurance amounts) or the GHP's allowable charge (without regard to any copayment imposed by the policy or plan) minus the amount actually paid by the GHP.

NOTE: In general, WC medical benefits constitute a service benefit (i.e., the payment constitutes full discharge of the patient's liability for services). In such cases, physicians/suppliers are obligated to accept the WC payment as payment in full and no secondary Medicare benefits are payable. However, if WC pays for Medicare covered services and, under the WC plan, the physician/supplier is not obligated to accept the payment as payment in full, Medicare secondary benefits may be payable.

To calculate the amount of Medicare secondary benefits payable on a given claim, it is generally necessary to have the following information not otherwise required in processing Medicare claims:

- The amount paid by the GHP; and
- The GHP's allowable charge.

This information can generally be derived from the GHP's explanation of benefits. In the event that the GHP's allowable charge cannot readily be determined from its explanation of benefits, the carrier assumes, in the absence of evidence to the contrary, that the actual charge is the GHP's allowable charge.

In the following examples, all physicians/suppliers have accepted assignment.

EXAMPLE 1

An individual received treatment from a physician who charged $175. The individual's Part B deductible had been met. As a primary payer, an employer allowed $150 of the charge and paid 80 percent of this amount or $120. The fee schedule amount for this treatment is $125. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $175 - $120 = $55.

B. The Medicare payment is determined in the usual manner: .80 x $125 = $100.

C. Employer plan's allowable charge of $150 (which is higher than Medicare's fee schedule amount of $125) minus the employer plan's payment of $120 equals $30.

D. Medicare pays $30 (lowest of amounts in steps A, B, or C).

EXAMPLE 2

An individual received treatment from a physician who charged $50. The individual's Part B deductible had been met. As a primary payer, an employer plan allowed a fee schedule payment of $20. The Medicare fee schedule amount for the treatment is $40. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $50 - $20 = $30.

B. The Medicare payment is determined in the usual manner: .80 x $40 = $32.

C. Medicare's fee schedule amount of $40 (which is higher than the employer plan's allowable charge of $20) minus the employer plan's payment of $20 equals $20.

D. Medicare pays $20 (lowest of amounts in steps A, B, or C).

EXAMPLE 3

An individual received treatment from a physician who charged $140. The individual's unmet Part B deductible was $100. As primary payer, an employer plan allowed $120 and paid 80 percent of this amount or $96. The Medicare fee schedule amount for his treatment is $110. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $140 - $96 = $44.

B. The Medicare payment is determined in the usual manner: $110 - $100 = $10 x .80 = $8.

C. Employer plan's allowable charge of $120 (which is higher than Medicare's fee schedule amount of $110) minus the employer plan's payment of $96 equals $24.

D. Medicare pays $8 (lowest of amounts in steps A, B, or C).

The beneficiary's Medicare deductible is credited with $100, which is the amount that would have been credited to the deductible based on the fee schedule amount of $110 if Medicare had been primary payer. (See Chapter 1, §40.)

The beneficiary can be charged $6 (the $110 fee schedule amount minus the sum of the $96 primary payment plus the $8 Medicare payment). (See Chapter 3, §10.2.1.)

EXAMPLE 4

An individual received treatment from a physician who charged $250. The individual had previously met $50 of the $100 Part B deductible for that year. As primary payer, an automobile insurer allowed the $250 charge in full. The insurer deducted $100 from the $250 physician charge to meet its own deductible and paid 80 percent of the remaining $150, or $120. The Medicare fee schedule amount for this treatment is $200. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $250 - $120 = $130.

B. The Medicare payment is determined in the usual manner: $200 - $50 = $150 x .80 = $120.

C. GHP's allowable charge of $250 (which is higher than Medicare's fee schedule amount of $200) minus its payment of $120 equals $130.

D. Medicare pays $120 (lowest of amounts in steps A, B, or C).

The beneficiary's Medicare deductible is credited with $50, the amount that would have been credited to the deductible based on the fee schedule amount of $200 payable if Medicare had been primary payer.

The beneficiary's Medicare deductible has now been met in full since $50 of the $100 deductible was met previously. (See Chapter 1, §40.)

The physician cannot bill the beneficiary because the sum total of the primary payment ($120) and the Medicare payment ($120) exceeds the fee schedule amount ($200).

EXAMPLE 5

An individual received treatment from a physician who charged $360. The individual paid the physician $50 and the physician also filed a claim with a GHP. The individual's unmet Medicare deductible was $100. The GHP's allowable charge was $250 and, as a primary payer, it paid the physician $200. The claim showed the total charge and other amounts paid by the GHP and the individual. The Medicare fee schedule amount for the treatment is $300. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $360 - $200 = $160.

B. The Medicare payment is determined in the usual manner: $300 - $100 = $200 x .80 = $160.

C. Medicare's fee schedule amount of $300 (which is higher than the EGHP's allowable charge of $250) minus the GHP's payment of $200 equals $100.

D. Medicare pays $100 (lowest of amounts in steps A, B, or C).

Since the physician collected $50 from the individual, the $100 Medicare payment is split: $50 goes to the individual and $50 goes to the physician. The beneficiary's Medicare deductible is credited with $100, the amount that would have been credited to the deductible based on the fee schedule amount of $300 if Medicare had been primary payer. (See Chapter 1, §40.)

The physician cannot bill the beneficiary because the sum total of the primary payment ($200) and the Medicare payment ($100) equals the fee schedule amount ($300). (See Chapter 3, §10.2.1.)

EXAMPLE 6

An individual received treatment from a physician who charged $175. The individual's Part B deductible had been met. As a primary payer, an employer plan allows $160 but has a preferred physician arrangement under which the physician agrees to accept 90 percent of the plan's allowable amount as payment in full (i.e., $144 ($160 x .90)). The plan also has a $50 deductible for physician services, which yet has not been satisfied in any part. Thus, the plan pays $94 ($144 preferred physician rate minus $50 deductible). The fee schedule amount for this treatment is $150. The Medicare secondary payment is calculated as follows:

A. The amount the physician is obligated to accept as payment in full minus the third party payment: $144 - $94 = $50.

B. The Medicare payment is determined in the usual manner: $150 x .80 = $120.

C. Employer plan's allowable charge of $160 (which is higher than Medicare's fee schedule amount of $150) minus the employer plan's payment of $94 equals $66.

D. Medicare pays $50 (lowest of amounts in steps A, B, or C).

EXAMPLE 7

Mr. Blue belongs to an employer-sponsored HMO that is primary to Medicare. He had 2 visits with a doctor for which he paid a $10 co-payment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payments to reimburse him for these co-payments.

The Medicare allowable amount for each of Mr. Blue's visits was $32 giving a total of $64 for the 2 visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

A. Determine the Medicare payment in the usual manner: .80 x $64 ($32 per visit x 2 visits) = $51.20.

B. The co-payments for the 2 visits total $20.

C. If the deductible had been met, the lowest of steps 1 or 2 would be payable. Since it was not met, the amount credited toward the deductible is:

- The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 x 2 = $64).

- To this amount, add the total co-payments for those covered services: $64 + ($10 x 2) = $84.

Mr. Blue is credited with $84 toward his deductible. Since Mr. Blue has not met the Medicare deductible, no MSP amount is payable.

40.7.4 - Effect of Medicare Limiting Charge on Medicare Secondary Payments

(Rev. 1, 10-01-03)

B3-3328.20.B

Under §1848(g)(1)(A) of the Social Security Act (the Act,) a nonparticipating physician/supplier who does not take assignment on a claim may not charge more than the Medicare limiting charge and no person is liable for payment of any amounts in

excess of the limiting charge. Effective January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians (See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," for further explanation of limiting charge.) Therefore, a nonparticipating physician/ supplier who does not take assignment must reduce their actual charge to the GHP, or to the beneficiary, to reflect the Medicare limiting charge. The rules above for calculating Medicare secondary benefits apply whether or not the limiting charge applies. However, when the limiting charge is less than the actual charge, the limiting charge will be considered to be the actual charge as well as the plan's allowable charge in applying those rules. This is because CMS cannot recognize an illegal charge as a basis for calculating Medicare benefits.

EXAMPLE

A physician erroneously billed $200 for a procedure. The GHP allowed $175 and paid $150 (which was more than it was obligated to pay under the Medicare limited charge law). The Medicare allowable amount for the nonparticipating physician is $125 (95 percent of the fee schedule amount for participating physicians in accordance with the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §30.3.12.3). The limiting charge is $143.75 (115 percent of $125). The secondary payment should be determined as follows:

A. The actual charge by the physician (the limiting charge) minus the GHP's payment: $143.75 - $150 = 0.

B. The Medicare payment is determined in the usual manner: .80 x $125 = $100.

C. Employer plan allowable charge (the limiting charge) minus the third party payments: $143.75 - $150 = $0

D. Medicare pays $0 (lowest of the amounts in A, B, or C).

40.7.4.1 - GHP Does Not Pay for Certain Services

(Rev. 1, 10-01-03)

B3-3328.20

When a GHP pays for certain services furnished to an individual but does not pay for other services or when the benefits available under the policy or plan have been exhausted, Medicare may pay primary benefits for the services not reimbursed by the GHP, provided they are otherwise covered.

EXAMPLE 1

A physician charges $600 for services related to an on-the-job injury. The physician also charges $400 for the services of an independent physical therapist in his or her office, which were for treatment of a preexisting condition unrelated to the job injury. The fee

schedule amount for the physician's services is $400 and the fee schedule for the therapist's services is $300. The beneficiary does not have GHP coverage. The beneficiary previously met the Medicare Part B deductible. Workers Compensation paid a fee schedule amount of $375 for the work-related injury, which the physician was required to accept as payment in full for services, but WC did not pay for physical therapy related to the preexisting condition. Since the WC payment is payment in full for the physician's services, no secondary Medicare benefits are payable for these services. However, Medicare may pay for the covered physical therapy services (provided by an independent physical therapist) not covered by WC. Medicare pays primary benefits of $240 (80 percent of the fee schedule amount of $300) for the independent therapist's services.

EXAMPLE 2

A beneficiary is injured in an automobile accident. The beneficiary is covered by no-fault insurance that has a $2,500 benefit limit. Over a 12-month course of treatment, a physician charges $1,400 for services and $1,800 for the services of an independent physical therapist in his or her office. The physician bills all charges to the no-fault insurer. The carrier determines that the fee schedule amount for the physician's services is $1,050 and $1,350 for the therapist's services. The beneficiary previously met the Part B deductible. The no-fault insurer paid the physician's charges in full and $1,100 of the therapist's charges for a total of $2,500 (policy limit of $2,500). Since the physician received full payment for the services, no secondary Medicare benefits are payable for these services.

However, Medicare may pay secondary benefits for the therapist's services because the no-fault insurance benefits are exhausted. The Medicare secondary payment amount is calculated as follows:

A. Actual charge of $1,800 minus the third party payment of $1,100 = $700.

B. The Medicare payment is determined in the usual manner: .80 x $1,350 = $1,080.

C. No-fault insurer's allowable charge of $1,800 (which is higher than Medicare's fee schedule amount of $1,350) minus the $1,100 paid by the insurer equals $700.

D. Medicare pays $700 (lowest of amounts in steps A, B, or C).

The physician cannot bill the beneficiary because the sum total of the primary payment ($1,100) and the Medicare secondary payment ($700) exceeds the fee schedule amount ($1,350). (See Chapter 3, §10.2.1.)

40.7.4.2 - Third Party Payment Includes Both Medicare Covered and Noncovered Services

(Rev. 1, 10-01-03)

B3-3328.20.D

To determine the amount of GHP payment for covered services when a bill includes both Medicare covered and noncovered services and it cannot be determined from the GHP's explanation of benefits how much of its payment is for Medicare covered services, the contractor allocates the third party payment proportionately to the Medicare covered and noncovered services. To do this, it determines the ratio of the charges for covered services to the total charges and multiplies the third party allowable charge and payment by that ratio. The results are, respectively, the third party allowable charge and the amount of the third party payment considered to be for Medicare covered services. The contractor computes the Medicare secondary payment amount in accordance with §40.7.3.

40.7.5 - Effect of Failure to File Proper Claim

(Rev. 1, 10-01-03)

B3-3328.21

The term "proper claim" means one that is filed in a timely manner and meets all other filing requirements specified by the GHP (e.g., mandatory second opinion, prior notification before seeking treatment).

When a physician, supplier, or beneficiary (who is not physically or mentally incapacitated) receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment is the amount that Medicare would have paid if the GHP had paid on the basis of a proper claim.

The physician, supplier, or beneficiary must inform CMS that a reduced payment was made and the amount that the GHP would have paid if a proper claim had been filed. If the carrier makes a greater secondary payment because the physician, supplier, or beneficiary fails to provide such notice and later discovers that the third party payment was a reduced amount because of failure to file a proper claim, the difference between the Medicare payment and the amount that Medicare should have paid on the basis of a proper claim for third party payment is an overpayment. The contractor recovers this amount, plus any applicable interest, from the party determined to be liable for the overpayment in accordance with the Medicare Financial Management Manual, Chapter 3, §§200 and 210.

EXAMPLE

A beneficiary receives services for which the physician's charges are $1,000. The primary payer's allowed charge is also $1,000, of which it would pay 80 percent or $800. However, the primary payer requires that the beneficiary receive a second opinion regarding the medical need for this service as a condition for filing a proper claim. Since the beneficiary failed to do so, the primary payer rejected the claim and refused to pay the beneficiary for the service. Medicare determines its secondary payment, in this case, as if the primary payer had paid on the basis of a proper claim. The Medicare fee schedule amount for this service is $800. The secondary payment is calculated as follows:

A. Actual charge by the physician minus what the GHP would have paid on the basis of a proper claim: $1,000 - $800 = $200.

B. The Medicare payment is determined in the usual manner: .80 x $800 = $640.

C. The primary payer's allowable charge of $1,000 (which is higher than Medicare's fee schedule amount of $800) minus the $800 the primary payer would have paid on the basis of a proper claim equals $200.

D. Medicare pays $200 (lowest of amounts in steps A, B, or C).

The beneficiary can be billed $800 by the physician (the amount of the third party payment reduction).

When failure to file a proper claim is due to the physical or mental incapacity of the beneficiary, the contractor considers the primary claim to have been properly filed and pays secondary benefits without regard to any third party benefit reduction attributable to failure to file a proper claim.

40.7.6 - Medicare Secondary Payment for Managed Care Organizations' (MCO) Copayments

(Rev. 1, 10-01-03)

B3-3328.23

Most Managed Care Organizations (MCOs) (e.g., HMOs, CMPs, Health Care Prepayment Plans (HCPPs)) charge copayment amounts for which Medicare Part B secondary payment may be made once the individual has met the Part B deductible. The deductible can be met either by covered services obtained outside the MCO or by covered services obtained through the MCO. The amounts credited to the deductible for MCO services are the Medicare allowable amounts that would have been allowed for the services if they had been furnished on a fee-for-service basis plus any copayments charged for the services. Once the deductible is met, the Medicare secondary payment is the amount Medicare would pay if the services were not covered by a GHP (the MCO) or the copayment amount, whichever is less. The MCO must file a claim showing all the

usual claims information except the amount of the charges and the amount paid since payment is made on a capitation basis.

If the MCO does not submit the claim, the carrier advises the MCO in writing that, under §1848(g)(4) of the Act, a claim must be submitted. Willful failure to comply within one year of the date of the service will subject the provider to a civil monetary penalty of up to $2,000 under §1842(p)(3) of the Act.

The carrier asks the beneficiary to submit the copayment receipts together with a signed statement explaining that the beneficiary is a member of an employer-sponsored MCO that is primary to Medicare and is requesting that Medicare pay secondary benefits for the MCO's copayment charges. This will serve as a substitute for the GHP's explanation of benefits notice.

The Medicare secondary payment would be the lesser of the:

- Amount Medicare would pay on the basis of the Medicare allowable amount if Medicare were primary, or
- MCO's copayment.

EXAMPLE 1

Mr. Green is enrolled in a non-Medicare HMO, which is his primary payer. His Part B deductible has been met. He required the services of a specialist and the HMO referred him to Dr. Smith who does not accept assignment. The doctor charged him a copayment of $25 for each visit. After eight visits, Mr. Green contacted the carrier requesting secondary benefits.

The carrier should request Mr. Green submit his copayment receipts with a dated statement that he is requesting secondary benefits from Medicare for the copayments he paid to the physician. This statement will then serve as Mr. Green's claim. Then the carrier requests the HMO to submit Form CMS-1500 showing the usual claims information, except for the charges and the amount paid.

The Medicare allowable amount for the nonparticipating physician was $55. The Medicare secondary payment is calculated as follows:

A. The Medicare payment is determined in the usual manner: .80 x $440 ($55 per visit x 8 visits) = $352.

B. The copayment for the 8 visits total $200 ($25 x 8).

C. Medicare pays $200, the total copayment, since that amount is lower than the amount Medicare would pay as primary payer.

EXAMPLE 2

Mr. Blue belongs to an employer sponsored HMO that is primary to Medicare. He had two visits with a doctor for which he paid a $10 copayment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payments to reimburse him for these copayments.

The Medicare allowable amount for each of Mr. Blue's visits was $32 giving a total of $64 for the two visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

A. The Medicare payment is determined in the usual manner: .80 x $64 ($32 per visit x 2 visits) = $51.20.

B. The copayments for the 2 visits totals $20.

C. If the deductible had been met, the lowest of steps A or B would be payable. Since it was not met, the amount credited toward the deductible is:

- The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 x 2 = $64).

- To this amount, the total copayments are added for those covered services: $64 + ($10 x 2) = $84.

Mr. Blue is credited with $84 toward his deductible. Since Mr. Blue has not met the Medicare deductible, no MSP amount is payable.

40.7.7 - Charging Expenses Against Annual Limit on Incurred Expenses for Services of Independently Practicing Physical Therapists

(Rev. 1, 10-01-03)

B3-3328.25

When services are provided by an independently practicing physical therapist, Medicare pays based on 80 percent of the fee schedule amount (incurred expenses). Expenses incurred for each type of therapy in a calendar year may not exceed a limit. (See the Medicare Claims Manual, Chapter 5 – Part B Outpatient Rehabilitation and CORF Services or the Medicare Benefit Policy Manual, Chapter 15, §230.4.for the annual limit applicable to therapy services.) Any portion of the Medicare fee schedule amount paid for by a GHP and credited toward the deductible is charged against the applicable limit on incurred expenses for services furnished by independently practicing physical therapists. However, amounts paid by a GHP after the Part B deductible has been met, do not count toward the limit that is recognized as incurred expenses.

An amount equal to 1.25 times the amount paid by Medicare is charged against the financial limit on incurred expenses for physical therapy services furnished by

independently practicing physical therapists. This is because Medicare pays 80 percent of the fee schedule amount for such services, while incurred expenses are equal to 100 percent of the Medicare fee schedule amount. Therefore, in order to properly determine the incurred expenses which are to be applied to the annual financial limit on incurred expenses, Medicare payment amounts, including secondary payment amounts, must be multiplied by a factor of 1.25 (100 percent of fee schedule amount) divided by .8 (80 percent payable by Medicare after deduction for coinsurance) = 1.25).

EXAMPLE

An individual received services from an independently practicing physical therapist for which the therapist charged $500. None of the individual's $100 Part B deductible had been met. A GHP allowed the charges in full and paid $400 (80 percent of $500). The Medicare fee schedule amount for the services was also $500. The first $100 in charges paid by the GHP is applied to the Part B deductible. The secondary Medicare benefit calculated in accordance with §30.4.1 is $100. The fee schedule financial limit on incurred expenses for services by independently practicing physical therapists is charged with the $100 credited to the Part B deductible plus $125 (1.25 x the $100 Medicare payment). Thus, $225 is applied to the financial limit.

40.8 - Intermediary Processing Procedures for Medicare Secondary Claims

(Rev. 1, 10-01-03)

A3-3490.3, A3-3685.B, A3-3685.C, HO-475

If a primary payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined below) in the absence of a primary payment, and the provider does not accept and is not obligated to accept the primary payment as payment in full, Medicare secondary benefits may be paid. In this situation, and where the employer plan paid an amount that equals or exceeds the amount that Medicare would have paid in the absence of a primary payment, the instructions below describe processing claims from providers on cost reimbursement, and providers on prospective payment.

If payment by the primary payer for Medicare covered services (as determined by the formula below) equals or exceeds the provider's full charges for those services or the Medicare gross payment amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the primary payment as payment in full for the services, and it receives this amount, no payment is due from Medicare and no inpatient utilization is charged to the beneficiary.

The provider submits a bill according to the procedures described in the Medicare Claims Processing Manual, Chapter 3, "Inpatient Hospital Billing," for no-payment bills.

40.8.1 - Medicare Secondary Payment Calculation Methodology When Proper Claim Has Been Filed

(Rev. 1, 10-01-03)

A3-IM-3497.2, A3-IM-3497.5 (This supersedes A3-3407.B.3, 3490.7, and 3491.11), A3-3682, A3-IM-3497.5, A3-3685.A.1, HO-475

A - Definition of Gross Amount Payable by Medicare

The gross amount payable by Medicare is the amount prior to deductions for the Medicare deductible and/or coinsurance amounts. It consists of:

- The current Medicare interim payment amount (see §40.8.2) for providers paid on a reasonable cost basis;
- The Medicare payment rate (see §40.8.2) for hospitals paid on a prospective payment basis;
- The composite rate for maintenance dialysis services; or
- The reasonable charge or fee schedule amounts.

If a provider furnishes services that are payable under more than one payment method (e.g., composite rate for dialysis treatments and reasonable cost for separately billable items associated with dialysis), Medicare determines the combined amount for the services as its gross amount payable without regard to the effect of the Medicare deductible, coinsurance, or payment by the third party payer.

For PPS providers, the Medicare payment rate is the amount Medicare would otherwise pay under PPS on an interim basis. It consists of the total prospective payment amount for the discharge and interim payments for those items that are paid retroactively. It is determined without regard to any deductible or coinsurance. The amount is computed in the same manner for PIP and non-PIP hospitals and is the sum of:

- The total prospective payment amount, as determined by PRICER, including payment for the DRG and any outlier payments, adjustments for hospitals serving a disproportionate share of low income patients, indirect medical education, payment for the hemophilia clotting factors for June 19, 1990, to December 19, 1991, and for cost reporting periods beginning on or after October 1, 1991, inpatient capital payment;
- Payment for direct graduate medical education activities (42 CFR 413.86) for cost reporting periods beginning on or after July 1, 1985; and
- A per diem payment for those items that are paid on a reasonable cost basis. See Provider Reimbursement Manual (PRM), §2405.2, for cost elements to be included in the payment. (For cost reporting periods beginning on or after July 1,

1985, direct graduate medical education activities are no longer paid on a reasonable cost basis.) The intermediary divides estimated payable costs for the current year by estimated Medicare days to compute a per diem rate. It multiplies the per diem rate by the number of days in the stay for which benefits are payable. Since the basic prospective payment is payable if a beneficiary has at least one covered day in the stay, payable days may exceed covered days if there are non-outlier days before entitlement or after benefits are exhausted.

40.8.2 - Rule to Determine the Amount of Secondary Benefits

(Rev. 1, 10-01-03)

A3-IM-3497.5.B, A3-3685.A.1, A3-3683, A3-3682.3.B.6, A3-3682.4.B.4, A3-3685.D, HO-473, HO-475, SNF-573, HH-498

The amount of secondary benefits payable to providers is the lowest of the following:

- The gross amount payable by Medicare (see definition for PPS providers and non-PPS providers above) minus the applicable deductible and/or coinsurance amount; or,

- The gross amount payable by Medicare minus the amount paid by the primary payer for Medicare covered services; or,

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the primary payer for Medicare covered services; or

- The provider's charges (or an amount less than the charges that the provider is obligated to accept in full), minus the applicable Medicare deductible and/or coinsurance amounts.

NOTE: When the primary payer pays less than actual charges (e.g., under the terms of a preferred provider agreement) and less than the amount the provider is obligated to accept as payment in full (e.g., because of imposition of a primary payer's deductible and/or copayment, but not because of failure to file a proper claim), Medicare uses the amount the provider is obligated to accept as payment in full in its payment calculation. In such cases, the provider reports in value code 44 the amount it is obligated to accept as payment in full. Medicare considers this amount to be the provider's charges. Absent a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used.

The provider uses condition code 77 to indicate it has accepted or is obligated/required due to a contractual arrangement or law to accept payment as payment in full. Therefore, no Medicare secondary payment is due.

The beneficiary has no liability for Medicare covered services if the primary payment is greater than the applicable Medicare deductible and coinsurance amounts. Otherwise, the

beneficiary's liability is limited to the applicable Medicare deductible and coinsurance amounts less the primary payment.

40.8.3 - Application of the MSP Formula

(Rev. 1, 10-01-03)

A3-3682.1.B.6, A3-3683, A3-3685.C, HO-472.3, HO-473, SNF-574, HH-498, HO-475

The Medicare payment amount is calculated by applying the following formulas:

A - Per Diem Payment

Medicare pays the lesser of covered days (visits) times per diem rate minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

OR

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductibles and coinsurance); or
- The amount paid by the primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

B - Prospective Payment

Medicare pays the lesser of the gross amount payable by Medicare, minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

OR

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, Items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

C - Percentage of Charge

Medicare pays the lesser of total charges (sum of covered and noncovered), identified by revenue code 001, less any Medicare noncovered charges times the percentage of charges used for the interim rate, minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

OR

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, Items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

D - Periodic Interim Payments (PIP)

Medicare pays the lesser of the per diem or per visit rate based on the provider's current PIP amount (See PRM, §2407) times the number of covered days (visits) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or
- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

OR

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductibles and coinsurance); or

- The amount paid by the primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

The intermediary uses the above formulas in calculating Medicare liability for prior year claims processed in the current year.

Providers also use these guidelines. The intermediary informs them of the applicable per diem (per visit) or percentage rates and of any changes.

The MSPPAY module provided by CMS calculates this payment. For documentation, refer to specifications distributed with the most recent module release.

EXAMPLE 1

A hospital furnished seven days of inpatient hospital care in 1998 to a Medicare beneficiary. The hospital's charges for Medicare covered services totaled $6,800. The primary payer paid $4,360 for Medicare covered services. No part of the Medicare inpatient hospital deductible of $764 had been met. The Medicare gross payment amount without regard to the deductible is $4,700. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $4,700 - $4,360 = $340;

- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $4,700 - $764 = $3,936;

- The hospital's charges minus the primary payer's payment: $6,800 - $4,360 = $2440; or

- The hospital's charges minus the Medicare inpatient deductible: $6,800 - $764 = $6,036.

Medicare pays $340. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $4,700. The beneficiary has no liability for Medicare covered services since the primary payer's payment satisfied the $764 inpatient deductible.

EXAMPLE 2

A hospital furnished one day of inpatient hospital care in 1998 to a Medicare beneficiary. The hospital's charges for Medicare covered services totaled $838. The primary payer paid $450 for Medicare covered services. No part of the Medicare inpatient hospital deductible of $764 had been met. The Medicare gross payment amount without regard to the deductible is $850. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $850 - $450 = $400;
- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $850 - $764 = $86;
- The hospital's charges minus the primary payer's payment: $838 - $450 = $388; or
- The hospital's charges minus the Medicare inpatient deductible: $838 - $764 = $74.

Medicare pays $74. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $524. The beneficiary's liability is $ 314 (the $764 deductible minus the $450 primary payer payment). The hospital can charge this amount to the beneficiary.

EXAMPLE 3

A hospital furnished five days of inpatient care in 1998 to a Medicare beneficiary. No part of the Medicare inpatient deductible of $764 had been met. The hospital's charges for Medicare covered services were $4,000 and the Medicare gross payment amount (without regard to the deductible) was $3,500. The provider agreed to accept $3,000 as payment in full. The primary payer paid $2,900 due to a deductible requirement under its plan. The amount the provider is obligated to accept as payment in full ($3,000) is considered by Medicare to be the hospital's charges in this situation. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $3,500 - $2,900 = $600;
- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $3,500 - $764 = $2,736;
- The hospital's charges minus the primary payer's payment: $3,000 - $2,900 = $100; or
- The hospital's charges minus the Medicare inpatient deductible: $3,000 - $764 = $2,236.

Medicare pays $100. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $3,000. The beneficiary has no liability for Medicare covered services since the primary payer's payment satisfied the $764 inpatient deductible.

EXAMPLE 4

A hospital furnished 20 days of inpatient hospital care to a Medicare beneficiary in 1998, and only coinsurance days were available. The hospital's charges were $5,000. The

deductible had been met. The primary payer paid $3,400 for Medicare covered services. The Medicare gross payment amount without regard to deductible and coinsurance is $4,600. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible or coinsurance) minus the primary payer's payment: $4,600 - $3,400 = $1,200;
- The Medicare gross payment amount (without regard to deductible or coinsurance) minus the applicable coinsurance: $4,600 - $3,820 (20 coinsurance days at $191 per day) = $780;
- The hospital's charges minus the primary payer's payment: $5,000 -$3,400 = $1,600; or
- The hospital's charges minus the applicable coinsurance: $5,000 -$3,820 = $1180.

Medicare pays $780. Since the primary payer's payment ($3,400) is less than the coinsurance ($3,820), full utilization is charged and coinsurance is determined in the usual manner. The beneficiary's liability is $ 420 (the $3,820 coinsurance minus the primary payer's payment or $3,400). This is the amount the hospital can charge the beneficiary.

EXAMPLE 5: HHA Per Visit Method

A beneficiary received 10 visits for which the HHA's current Medicare interim payment amount at $50 per visit was $500 (the gross payment amount). The HHA's charges were $580. The primary payer paid $300 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The current Medicare gross payment amount minus the amount paid by the primary payer for Medicare covered services: $500 - $300 = $200; or
- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $580 - $300 = $280.

Medicare pays $200 as secondary payer.

EXAMPLE 6: HHA Percentage of Billed Charges Method

A beneficiary received 10 visits for which the HHA charged $50 per visit. The interim rate was 90 percent ($500 X 90 percent), which equaled $450 (the gross Medicare payment amount). The primary payer paid $300 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The current Medicare gross payment amount minus the amount paid by the primary payer for Medicare covered services: $450 - $300 = $150; or

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $500 - $300 = $200.

Medicare pays $150.

EXAMPLE 7: HHA Billing for DME

A beneficiary not under a plan of treatment purchased an item of DME for which the HHA charged $3,500. No part of the $100 Part B deductible had been met. The Medicare final payment without regard to the deductible and coinsurance for this item of DME was $3,300 (the lower of the $3,500 charges or the $3,300 fee schedule amount). The primary payer paid $3,000 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus the amount paid by the primary payer for Medicare covered services: $3,300 - $3,000 = $300;

- The Medicare gross payment amount (without regard to deductible or coinsurance) minus any applicable Medicare deductible and/or coinsurance amounts: $3,300 - $100 - *$640 = $2,560;

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $3,500 - $3,000 = $500; or

- The HHA's charges minus any applicable Medicare deductible and/or coinsurance amounts: $3,500 - $100 - *$640 = $2,760.

*The coinsurance is calculated as follows:

$3,300 fee schedule amount - $100 deductible = $3,200 x 20% = $640 coinsurance.

Medicare pays $300. The HHA may not charge the beneficiary since the deductible and coinsurance were met by the primary payer's payment. (For the Provider Statistical and Reimbursement Report (PS&R,) the intermediary records $100 deductible, $640 coinsurance and $2,260 primary payer's payment.)

EXAMPLE 8: HHA Accepted Amount Less Than Charges

Same facts as in Example 3 except the HHA agreed to accept $3,200 from the primary payer and the primary payer paid $3,100 due to the deductible requirement under its plan. The amount the HHA is obligated to accept as payment in full ($3,200) is considered by Medicare to be the HHA's charges in this situation. As secondary payer, Medicare pays the lower of:

- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus the amount paid by the primary payer for Medicare covered services: $3,300 - $3,100 = $200;

- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus any applicable Medicare deductible and/or coinsurance amounts: $3,300 - $100 - $640* = $2,560;

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $3,200 - $3,100 = $100; or

- The HHA's charges minus any applicable Medicare deductible and/or coinsurance amounts: $3,200 - $100 - $640* = $2,460.

*See Example 3 for coinsurance calculation.

Medicare pays $100. The beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R, the intermediary records $100 deductible, $640 coinsurance and $2,360 primary payer payment.)

40.8.4 - PIP Reduction

(Rev. 1, 10-01-03)

A3-3682.2

For providers on PIP (see PRM, Part I, §2405.l.b), the intermediary reduces the PIP amount for prospective payments or interim payments (for non-PPS providers) to reflect any excess of the primary payment amount over the applicable deductible and coinsurance amount. Where Medicare is determined not to have any liability, the intermediary reduces the PIP amount to reflect that no interim payment is due. Where Medicare is determined to be secondarily liable, the intermediary reduces the PIP amount to reflect any excess of the primary payment over the applicable deductible and coinsurance. Any reduction in PIP payments is accomplished by offsetting against the next payment or by taking estimated reductions into account in establishing the PIP payment level. All adjustments resulting from primary payment amounts are reflected only in the PIP payment level.

NOTE: No reduction is made to the PIP amount with regard to conditional payments since in these situations payment is made, although conditionally, as if Medicare were fully liable for the stay.

If the applicable Medicare deductible and coinsurance or the primary payment amount exceeds the total prospective payment amount, the intermediary subtracts the excess from prospective payments due the hospital for other discharges. It does not adjust biweekly payments for direct graduate medical education activities and for items that are paid on a reasonable cost basis as a result of primary payment amounts. Biweekly payment is the method by which these amounts are paid on an interim basis for both PPS-PIP and PPS non-PIP hospitals. (See PRM Part I, §2405.2 and 2405.3.) A primary payment amount in excess of the total prospective payment amount for a particular discharge need not be, identified to, and subtracted from, the biweekly payments because the hospitals cost

report provides for subtraction of total primary payments from the aggregate of all Medicare payments otherwise due.

40.8.5 - MSP Part B Claims (Outpatient and Other Part B Services, Home Health Part B and Ancillary Services When Part A Benefits are Exhausted)

(Rev. 1, 10-01-03)

A3-3682.2.A, A3-3682.1.C, HO-472.3

These provisions apply to outpatient and other Part B services, Home Health Part B and ancillary services for individuals who have exhausted their Part A benefits.

If payment by the primary payer for Medicare covered services (as determined by the formula above) equals or exceeds the provider's charges for those services or the current Medicare gross payment amount (without regard to the deductible or coinsurance) or the provider accepts, or is obligated to accept, the primary payer's payment as payment in full and it receives at least this amount and the provider knows the individual has already met the outpatient deductible, no bill is submitted. However, a bill is submitted where the deductible may not yet be met. Although Medicare can make no payment, the expenses can be applied to the beneficiary's deductible. The provider completes the bill according to the instructions in the Medicare Claims Processing Manual. In addition, the provider determines the charges as usual, including those covered by the primary payer's payment.

The charges shown in total charges are treated as noncovered for payment purposes. When the primary payer amount satisfies the claim in full, the intermediary does not record the deductible, coinsurance, or charges on the PS&R.

EXAMPLE 1: Primary Payer's Payment Is Less Than Unmet Deductible

A Medicare beneficiary incurred $120 of covered charges for outpatient services. No part of the beneficiary's $100 Part B deductible had been met. The primary payer paid $97 for Medicare covered services. The current Medicare gross payment (without regard to the deductible or coinsurance) for these services at 95 percent of charges (the provider's interim rate) is $114. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $114-$97 = $17;
- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $114-$100-$4* = $10;
- The provider's charges minus the primary payer's payment: $120 - $97 = $23; or
- The provider's charges minus the applicable Medicare deductible and coinsurance: $120 -$100 - $4* = $16.

*The coinsurance is calculated as follows:

$120 charges - $100 deductible = $20 x 20% = $4 coinsurance.

Medicare pays $10. The beneficiary's liability is $7 ($3 of the deductible and $4 coinsurance).

The beneficiary's $100 deductible is satisfied: $97 by the primary payer's payment and $3 by the beneficiary.

(For the PS&R, the intermediary records $100 deductible and $4 coinsurance.)

EXAMPLE 2: Primary Payer's Payment Is More Than Unmet Deductible

Same facts as in Example 1 except the primary payer's payment for Medicare covered services is $105:

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $114 - $105 = $9;
- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $114 - $100 -$4* = $10;
- The provider's charges minus the primary payer's payment: $120 - $105 = $15; or
- The provider's charges minus the applicable Medicare deductible and coinsurance: $120 -$100 - $4* = $16.

(*See Example 1 for coinsurance calculation.)

Medicare pays $9. The provider may not charge the beneficiary since the deductible and coinsurance were met by the primary payer's payment. (For the PS&R, the intermediary records $100 deductible, $4 coinsurance, and $1 primary payment.)

EXAMPLE 3: Primary Payer's Payment Equals Unmet Deductible

Same facts as in Example 1 except the primary payer's payment for Medicare covered services is $100:

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $114 - $100 = $14;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $114 - $100 -$4* = $10;

- The provider's charges minus the primary payer's payment: $120 - $100 = $20; or

- The provider's charges minus the applicable Medicare deductible and coinsurance: $120 -$100 - $4* = $16.

(*See Example 1 for coinsurance calculation.)

Medicare pays $10. The provider may bill the beneficiary $4 for coinsurance. The $100 deductible is satisfied by the primary payer's payment. (For the PS&R, the intermediary records $100 deductible and $4 coinsurance.)

EXAMPLE 4: Deductible Met Prior To Primary Payer's Payment

Same facts as in Example 1, except the deductible has been met.

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $114 - $97 = $17.

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare coinsurance: $114 - $24* = $90;

- The provider's charges minus the primary payer's payment: $120 - $97 = $23; or

- The provider's charges minus the applicable Medicare coinsurance: $120 - 24* = $96.

*The coinsurance is calculated as follows:

$120 charges x 20% = $24 coinsurance.

Medicare pays $17. The hospital may not charge the beneficiary since the coinsurance is paid by the primary payer's payment. (For the PS&R, the intermediary records $24 coinsurance and $73 primary payer payment.)

EXAMPLE 5: Amount Provider Accepted Less Than Charges

A Medicare beneficiary incurred $450 covered charges for outpatient services, and the current Medicare gross payment amount (without regard to the deductible and coinsurance) was $400. The provider agreed to accept $350 from the primary payer. The primary payer paid $300 due to a deductible requirement under its plan. The amount the provider is obligated to accept as payment in full ($350) is considered by Medicare to be the provider's charges in this situation. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $400 - $300 = $100;

- The current Medicare gross payment amount (without regard to deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $400 - $100 = $300 - $70* = $230;

- The provider's charges minus the primary payer's payment: $350 - $300 = $50; or

- The provider's charges minus the applicable deductible and coinsurance: $350 - $100 = $250 - $70* = $80.

*The coinsurance is calculated as follows:

$450 charges - $100 deductible = $350 x 20% = $70 coinsurance.

Medicare pays $50. The provider may not charge the beneficiary since the beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R report, the intermediary records $100 deductible, $70 coinsurance and $130 primary payment.)

EXAMPLE 6: Composite Rate

An ESRD beneficiary received eight dialysis treatments for which a facility charged $160 per treatment for a total of $1,280. No part of the beneficiary's $100 Part B deductible had been met. The primary payer paid $1,024 for Medicare covered services. The composite rate per dialysis treatment at this facility is $131 or $1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $1,048 - $1,024 = $24;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $1,048 - $100 - *$189.60 = $758.40;

- The provider's charges minus the primary payer's payment: $1,280 - $1,024 = $256; or

- The provider's charges minus the applicable deductible and coinsurance: $1,280 - $100 - *$189.60 = $990.40.

*The coinsurance is calculated as follows:

$1,048 composite rate - $100 deductible = $948 x 20% = $189.60 coinsurance.

Medicare pays $24. The provider may not charge the beneficiary since the beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment.

(For the PS&R, the intermediary records $100 deductible, $189.60 coinsurance, and $734.40 primary payment.)

EXAMPLE 7: Composite Rate

An individual received 12 peritoneal dialysis treatments over a one-month period for which an independent facility charged $150 per treatment. The facility bills on a monthly basis and its per treatment composite rate is $130 ($1,560 for 12 treatments). The facility also billed the individual separately for billable parenteral items for which it charged $45. The Medicare reasonable charge for these services is $36. The beneficiary's $100 Part B deductible was previously met. The primary payer paid 80 percent of the facility's charges or $1,476 for Medicare covered services. As secondary payer, Medicare pays the lowest of:

- The composite rate plus the Medicare reasonable charge for the separately billable services (without regard to the deductible or coinsurance) minus the primary payer's payment: $1,560 + $36 = $1,596 - $1,476 = $120;

- The composite rate plus the Medicare reasonable charge for the separately billable services (without regard to the deductible or coinsurance) minus the applicable coinsurance: $1,560 + $36 = $1,596 - $319.20* = $1,276.80;

- The provider's charges minus the primary payer's payment: $1,800 + $45 = $1,845 - $1,476 = $369; or

- The provider's charges minus the applicable coinsurance: $1,800 + $45 = $1,845 - $319.20* = $1,525.80.

*The coinsurance is calculated as follows:

$1,596 composite rate x 20% = $319.20 coinsurance.

Medicare pays $120. The facility may not charge the beneficiary since the coinsurance was met by the primary payer's payment. (For the PS&R, the intermediary records $319.20 coinsurance and $1,156.80 primary payment.)

40.8.6 - MSP Outpatient Claims Involving Lab Charges Paid by Fee Schedule

(Rev. 1, 10-01-03)

A3-3695.A, HO-477

The following procedures describe how to prorate primary payments for MSP outpatient claims which include charges for clinical diagnostic lab services (paid on the basis of 100 percent of a fee schedule) and charges for nonlab services (subject to the regular deductible and coinsurance requirement) when a primary payer pays in part for the services, without designating how much of its payment is for each type of service.

40.8.6.1 - Prorating Primary Payments

(Rev. 1, 10-01-03)

A3-3695.B

The intermediary prorates the undesignated primary payer's payment for Medicare covered services by applying a ratio of this payment between lab and nonlab charges on the bill to determine what portion of the primary payer's payment is attributable to the nonlab charges.

NOTE: This ratio is based upon Medicare billed charges and not Medicare's payment under the fee schedule.

40.8.6.2 - Calculation of Deductible and Coinsurance

(Rev. 1, 10-01-03)

A3-3695.C

The intermediary calculates deductible and coinsurance in the usual manner after applying the primary payer's payment allocated for nonlab services. See examples below for calculation of coinsurance.

EXAMPLE 1: Deductible Previously Met

Outpatient services were furnished to a Medicare beneficiary for whom the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. The beneficiary's Part B deductible was previously met. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to nonlab charges is $100/$200, the intermediary divides the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. It applies $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in nonlab charges (emergency room services). It calculates the coinsurance in the usual manner based upon the $200 nonlab charges. It does not charge coinsurance since the primary payment of $100 allocated to nonlab charges is greater than the $40 coinsurance on the $200 in nonlab charges. (For the PS&R, the intermediary records $40 coinsurance and $60 primary payment.)

EXAMPLE 2: Deductible Not Met

Outpatient services were furnished to a Medicare beneficiary for whom the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. Only $25.00 of the beneficiary's Part B deductible had been met previously leaving the remaining $75.00 to be met. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to nonlab charges is

$100/$200, the intermediary divides the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. It applies $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in nonlab charges (emergency room services). It calculates the deductible and coinsurance in the usual manner based upon the $200 nonlab charges. It does not charge any deductible or coinsurance since the primary payment of $100 allocated to nonlab charges is equal to the $25 coinsurance and $75 remaining deductible on the $200 in nonlab charges. (For the PS&R, the intermediary records $75 deductible and $25 coinsurance.)

40.8.7 - Calculating Medicare Secondary Payments When Proper Claim Has Not Been Filed With Third Party Payer

(Rev. 1, 10-01-03)

A3-IM-3497.5, A3-IM-3497.6

A "proper claim" means one that is filed timely and meets all other filing requirements specified by the third party payer (e.g., mandatory second opinion, prior notification before seeking treatment).

When a provider, or a beneficiary who is not physically or mentally incapacitated, receives no third party payment, or a reduced third party payment, because of failure to file a proper claim, the Medicare secondary payment is the amount that Medicare would have paid if the third party payer had paid on the basis of a proper claim. The intermediary calculates this amount with the rules in §30.5.1, except that the phrase "the amount the third party would have paid for Medicare covered services if a proper claim had been filed with the third party" is substituted for the phrase "amount payable by the third party for Medicare covered services."

The provider must inform CMS that the third party payer has made no payment, or a reduced payment, and the amount that the third party payer would have been paid if a proper claim had been filed. If the intermediary makes a greater secondary payment because the provider fails to provide such notice, and it is later discovered that the third party made no payment, or paid a reduced amount, because of failure to file a proper claim, the difference between the Medicare payment and the amount Medicare should have paid, on the basis of a proper claim for third party payment, is an overpayment. The intermediary recovers this amount in accordance with the instructions in Chapter 7, §10.

However, when failure to file a proper claim is attributable to the physical or mental incapacity of the beneficiary, the intermediary considers the primary claim to have been properly filed, and pays secondary benefits without regard to any third party benefit reduction attributable to failure to file a proper claim.

EXAMPLE

A beneficiary receives services for which a hospital's charges are $10,000. The primary payer would pay $9,900 on a properly filed claim. However, the primary payer requires that the beneficiary submit a second opinion regarding the medical need for a hospital admission as a condition for filing a proper claim. Since the beneficiary failed to do so, the primary payer reduced its payment by 50 percent; i.e., the plan paid $4,950. Medicare determines its secondary payment, in this case, as if the primary payer had paid on the basis of a proper claim. The Medicare gross payment amount (total prospective payment amount without regard to deductible and coinsurance amount) is $10,000. The secondary payment is calculated as follows:

A - The Medicare gross payment amount minus the applicable Medicare deductible amount:

$10,000 - $676 = $9,324.

B - The Medicare gross payment amount minus the amount the primary payer would have paid on the basis of a proper claim:

$10,000 - $9,900 = $100.

C - The hospital's charges (or an amount the hospital is obligated to accept as payment in full), minus the amount the primary payer would have paid on the basis of a proper claim:

$10,000 = $9,900 = $100.

D - The hospital's charges (or an amount the hospital is obligated to accept as payment in full), minus the applicable Medicare deductible and/or coinsurance amounts:

$10,000 - $676 = $9,324.

E - Medicare pays $100 (lowest of amounts in steps 1, 2, 3, or 4).

The beneficiary can be billed $4,950 by the hospital (the amount of the primary payer reduction).

40.8.8 - Determining Patient Utilization Days, Deductible, and Coinsurance Amounts

(Rev. 1, 10-01-03)

A3-3682.B.3, A3-3682.1.B, A3-3685.A.3, A3-IM-3497.6, A3-IM-3497.7, HO-472.3, HO-475, A3-3491.12

Where a primary payer pays an amount for Medicare covered services that is equal to or less than the deductible and coinsurance that would apply if Medicare was the primary

payer, Medicare charges full utilization. Therefore, it calculates coinsurance in the usual manner.

Where a primary payer pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare were the primary payer, Medicare charges utilization only to the extent that it paid for the services.

The MSP payment modules calculate days to be charged to the beneficiary's utilization. The intermediary reports the result in the in the appropriate field of the CWF record as described in CWF documentation. The procedures below describe how utilization and coinsurance are charged.

If payment by the primary payer for Medicare covered services is less than the provider's charges for those services and the current Medicare interim payment amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the primary payer payment as payment in full, the intermediary follows the procedures below to determine utilization and coinsurance applicable.

Where the stay involves coinsurance days, the intermediary determines utilization chargeable to the beneficiary. It completes item 39 (coinsurance value codes and amounts) accordingly. No adjustment to item 7 (covered days) is made based on this determination. The provider completes item 7 in the usual manner.

The intermediary charges utilization as follows:

- It determines the Medicare secondary payment amount in accordance with §§30.5.1 or 30.5.2 above;

- It divides this amount by the amount that Medicare would have paid as primary payer. This is the Medicare interim payment for the stay reduced by the deductible and coinsurance for non-PPS providers or the Medicare payment rate reduced by deductible and coinsurance for PPS providers; and

- It multiplies this percentage by the number of covered days in the stay or for PPS providers, the number of payable days in the stay.

The intermediary does not charge a partial day resulting from this calculation as a full day if it is less than a half of a day. It charges a full day if it is a half day or more.

For PPS providers, where the number of payable days in the stay exceeds the number of days for which benefits are available (e.g., benefits are exhausted during the nonoutlier portion of the stay), the number of utilization days charged may not exceed the actual days available. If regular benefit days are exhausted during the basic portion of the stay and lifetime days are used for the outlier portion of the stay, the intermediary separately computes the chargeable days for each portion of the stay.

The intermediary charges coinsurance days as follows:

- If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed; or

- If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, intermediaries must perform the same calculation to verify that item 39 (coinsurance value codes and amounts) are completed correctly. The intermediary advises the provider of any discrepancies.

EXAMPLE 1: Deductible Involved - PPS (no outlier involved) or Non-PPS Hospital

In 1998, an individual was hospitalized 15 days for which total charges were $5,000. The primary payer paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $764 had been met. The Medicare gross payment amount (without regard to the deductible or coinsurance) for the services absent the primary payer's payment would have been $3,600. The Medicare secondary payment is $1,200 ($3,600 - $2,400). Medicare would have paid $2,836 as primary payer ($3,600 - $764). The intermediary calculates the beneficiary's utilization as follows: $1,200 divided by $2,836 = .423 x 15 days = 6.34 or 6 days, when rounded.

EXAMPLE 2: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

In 1998, an individual was hospitalized for 20 days (all of which are lifetime reserve days) for which total charges were $20,000. The primary payer paid $13,000 for Medicare covered services. The applicable coinsurance amount was $ 7,640. The current Medicare interim payment amount (without regard to the deductible or coinsurance) for the services, absent the primary payer's payment, would have been $17,000. The Medicare secondary payment amount is $4,000 (the Medicare gross payment amount of $17,000 minus the primary payer's payment of $13,000). Medicare would have paid $9,360 as primary payer ($17,000 - $7,640). The intermediary calculates the beneficiary's utilization as follows: $4,000 divided by $ $9,360 = .427 x 20 days = 8.5 or 9 days when rounded. If the primary payer's payment in this example had been $7,640 or less, full utilization would have been charged. The beneficiary would have been charged with 20 days utilization.

EXAMPLE 3: Primary Payer Pays for Specified Number of Days - PPS (no outlier involved) or Non-PPS Hospital

The intermediary uses this formula even when the primary payer pays for only a specified number of days of a stay because of a payment limitation under the plan based upon the number of benefit days available. For example, in 1998, a provider furnished 20 days of inpatient care. The primary payer paid all of the charges for the first 10 days. These charges were $4,500. No part of the Medicare inpatient deductible of $764 had been met. The current Medicare gross payment amount (without regard to the deductible or coinsurance) that Medicare would have paid for the 20-day stay, absent primary payer

coverage, was $7,000. The Medicare secondary payment is $2,500 ($7,000 - $4,500). Medicare would have paid $ 6,236 as primary payer ($7,000 - $764). The intermediary calculates the utilization charged to the beneficiary as follows: $2,500 divided by $6,236 = .400 X 20 days = 8.01 days or 8, days when rounded.

EXAMPLE 4: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 17 full days available at admission. The inpatient stay was 20 days. The provider bills 20 days in covered days (form locator 7 of the UB-92) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed.

Absent any other insurer's payment, three days are billed in form locator 9 (coinsurance days) with value code 9 or 11 and value amount in item 39 (coinsurance value code and amount) and 20 days are in the "Cost Report Days" field of the CWF record.

EXAMPLE 5: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 30 coinsurance days available at admission. The hospital stay was 20 days. The provider bills 20 days in covered days (form locator 7) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed.

Absent any other insurer's payment, 20 days are billed in form locator 9 (coinsurance days) with value code 9 or 11 and the value amount in form locator 39 (coinsurance value code and amount).

The intermediary enters 10 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF Record.

Absent any other insurer's payment, 20 days are billed in form locator 9 (coinsurance days) with value code 9 or 11 and the value amount in form locator 39 (coinsurance value code and amount).

In this case, the intermediary enters 20 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF record.

EXAMPLE 6: PPS Hospital

A beneficiary enters the hospital with two lifetime reserve days (LTR) remaining and elects to use them. The beneficiary is discharged after 15 days before the outlier threshold is reached. The Medicare payment rate is $5,000. The primary payer amount for Medicare covered services is $3,000. The applicable coinsurance amount is $764 (2

LTR days at $382 a day). Medicare would have paid $4,236 as primary payer ($5,000 - $764).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Utilization days potentially chargeable equal:

$2,000 divided by $4,236 X 15 days = 7 days

In this case, charge only the actual days of coverage in the stay, or two days, for utilization and cost reporting purposes.

EXAMPLE 7: PPS Hospital - CY 2001 Stay

A beneficiary enters the hospital with two regular coinsurance days remaining and is discharged after 15 days. The primary payer amount for Medicare covered services (i.e., the entire stay) was $3,000. The Medicare payment rate is $5,000. The applicable coinsurance amount is $396 (2 coinsurance days at $198 a day). Medicare would have paid $4,604 as primary payer ($5,000 - $396).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Regular benefit days chargeable =

$2,000 divided by $4,604 X 10 days in basic portion of stay = 7 days

Charge the beneficiary two coinsurance days, since only two days were available.

Lifetime reserve days chargeable =

$2,000 divided by $2,708 X 5 days in outlier portion of stay = 3.6 rounded to 4 days.

Charge the beneficiary for lifetime reserve days and determine coinsurance on this basis.

40.8.9 - Benefits Exhausted Situations When Medicare Is Secondary Payer for Reasonable Cost Providers

(Rev. 1, 10-01-03)

A3-3684, HO-474, SNF-574

If Medicare has secondary liability for an inpatient stay, services that would otherwise not be covered because the beneficiary had exhausted benefits may be covered after the impact of the primary payment on utilization is determined. Since the primary payment extends the covered portion of the beneficiary's stay, it affects Medicare covered charges in situations where benefits are exhausted. At the same time, the ratio of Medicare covered charges to total charges determines the portion of the primary payment that is

allocated to Medicare covered services. The intermediary considers the primary payment's effect upon Medicare covered services before allocating the primary payment.

To determine Medicare covered charges in benefits exhausted situations in other than a PPS hospital, the intermediary proceeds as in the example below, in which Medicare benefits were exhausted after the seventh hospital day. For PPS hospitals, see §40.8.8.

EXAMPLE

Total Charges	$5,000
Medicare Covered Charges (without regard to benefits exhausted)	$4,500
Medicare Covered Charges for Day 1-7	$3,000
Primary Payment (unallocated)	$3,000
Remaining Benefit Days	3
Covered Medicare Days (without regard to benefits exhausted)	10
Current Medicare Per Diem Interim Payment Rate	$ 480

Step 1. The intermediary determines what the current Medicare interim payment would be if benefits were not exhausted (and no primary payments were involved).

EXAMPLE

$480 X 10 days = $4,800

Step 2. The intermediary determines the amount of the primary payment that would apply to Medicare services if benefits were not exhausted.

- If the primary payer's allocation can be determined, the intermediary uses it.

EXAMPLE

The primary payer's explanation of benefits indicates that the $3,000 primary payment was for the first 5 days of the stay. Medicare, in the absence of a primary payer would have paid $3,000 for 7 days. Since the primary payer paid for 5 of the 10 days of the stay, Medicare has responsibility for the 5 remaining days. Medicare would have covered $3,000 for 7 days. It covers 5/7 of $3,000, or $2,143 for the 5 days for which it is responsible.

- If the primary payer's allocation cannot be determined, the intermediary applies a ratio of Medicare covered charges (without regard to benefits exhausted) to total

charges for the stay to the total primary payment to determine the portion that would be attributable to Medicare.

EXAMPLE

$4,500 / $5,000 X $3,000 = $2,700

Step 3. The intermediary determines the Medicare secondary payment that would be made in the absence of benefits exhausted (without regard to deductible or coinsurance) by subtracting Step 2 from Step 1.

EXAMPLE

$4,800 - $2,700 = $2,100

Step 4: The intermediary determines the benefit days that would be chargeable absent benefits exhausted by applying a ratio of Step 3 to Step 1 to the number of Medicare covered days without regard to benefits exhausted.

EXAMPLE

$2,100 / $4,800 X 10 = 4.375

Step 5: The intermediary determines the number of days for which benefits are actually available.

EXAMPLE: 3 days

Step 6: If the number of days in Step 5 is greater than the number of days in Step 4, the primary payment extends Medicare coverage over the entire stay. The case no longer involves benefits exhaustion. All otherwise covered days and charges are reported as covered for statistical and payment purposes. The amount in Step 3 is the Medicare secondary payment (without regard to the deductible or coinsurance) and the number of days determined in Step 4 are charged to the beneficiary's utilization record.

Step 7: If the number of days in Step 5 is less than the number of days in Step 4, the beneficiary does not have sufficient benefit days available to cover the entire stay. The intermediary proceeds as follows:

- It charges the days in Step 5 to the beneficiary's utilization record.

EXAMPLE: 3 days

- It multiplies the number of Medicare covered days without regard to benefits exhausted by the ratio of the number of days in Step 5 to the number of days in Step 4 to determine the days recorded as covered for statistical purposes.

EXAMPLE

3 / 4.375 X 10 = 6.86 = 7 days

Charges for days 1-7 are shown as covered on the bill. Charges for days 8-10 are reported as noncovered.

- The intermediary re-determines the allocation of the primary payer's payment for covered services based upon the revised Medicare covered charges.

EXAMPLE

$3,000 / $5,000 X $3,000 = $1,800

- The intermediary determines Medicare current interim payment for days recorded as covered for statistical purposes.

EXAMPLE

$480 X 7 days = $3,360

- The intermediary determines Medicare's secondary payment.

EXAMPLE

$3,360 - $1,800 = $1,560

40.8.10 - Deductible and/or Coinsurance Rates Spanning Two Calendar Years

(Rev. 1, 10-01-03)

A3-3688, HO-476, SNF-575

Where Medicare is secondarily liable because another payer primary to Medicare has made payment on an inpatient claim and the stay spans two calendar years, the provider bills the deductible and/or coinsurance rate applicable to the year in which Medicare utilization is charged. Medicare utilization (calculated in accordance with the above instruction) is charged beginning with the first day of the stay. This rule applies even though the primary payer paid for only a specified number of days of a stay, e.g., the primary payer's plan covers the first 20 days of a 30-day stay.

Where Medicare utilization involves coinsurance days spanning two calendar years, the provider bills coinsurance for each coinsurance day in accordance with the applicable coinsurance rate for the year in which the day was used. The provider uses value codes 09 and 11, form locators 39 through 41, to show specific coinsurance amounts. See CWF documentation for reporting coinsurance days on the CWF record.

EXAMPLE l

A beneficiary is in a new benefit period and was admitted to the hospital on December 15, 1997, and discharged on January 14, 1998. An insurer primary to Medicare paid the first 20 days of the stay. The provider bills $760 deductible (the applicable deductible for the first year in which Medicare utilization is charged).

EXAMPLE 2

A beneficiary was admitted to the hospital on December 15, 1997, and discharged on January 14, 1998. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 15 thru December 24). The provider bills 10 days coinsurance at the 1997 rate ($190 x 10 = $1,900). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used.

EXAMPLE 3:

A beneficiary was admitted to the hospital on December 25, 1997, and discharged on January 24, 1998. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 25, 1997 thru January 3, 1998). The provider bills 7 days coinsurance at the 1997 rate ($190 x 7 = $1,330) and 3 days coinsurance at the 1998, rate ($191 x 3 = $573). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used. The data is reported on the Form CMS-1450 as follows:

- Value Code 09, Medicare Coinsurance Amount in First Calendar Year = $1,330.00;
- Value Code 11, Medicare Coinsurance Amount in Second Calendar Year = $573.00;
- Form Locator 9, Coinsurance Days =10

40.8.11 - Submit Data to CWF When Full Payment Made by Primary Payer

(Rev. 1, 10-01-03)

A3-3682.1.A, A3-3682.3.A, HO-472.3

Rules concerning submitting data to CWF if the Medicare payment amount is zero are as follows:

- If the MSP payment module determines that the Medicare payment amount is zero, contractors do NOT complete the nonpayment code;

- The "Utilization Days" field of the CWF record contains the days the MSP payment module determines to be charged to the beneficiary's utilization record. If the Medicare payment amount is zero, this figure must also be zero;

- The "Cost Report Days" field of the CWF record contain zero days;

- The "Value Code" field in the value data portion of the CWF record contains the appropriate value code to identify the primary payer. (See the Medicare Claims Processing Manual, Chapter 25, §60, Field Locators 39-41, for appropriate value codes.);

- The "Value Amount" field in the value data portion of the CWF record contains the amount Medicare would have paid in the absence of the primary payer's payment. (The intermediary does **NOT** record this amount on the PS&R.);

- The intermediary does not record days or charges on the PS&R; and,

- The intermediary submits the bill to CMS in accordance with CWF documentation.

The CMS uses data reported in the blood deductible and inpatient deductible items to update deductibles. (This data is not used for the PS&R.)

40.8.12 - Submit Data to CWF When Partial Payment Made by Primary Payer

(Rev. 1, 10-01-03)

A3-3682.1.A, A3-3682.B.7, A3-3682.4, A3-3682.1.B.7, A3-3682.2.B.5, HO-472.3

Intermediaries submit data concerning the patient's utilization days, deductible, coinsurance amounts and MSP payment amounts to CWF. Utilization days used and deductible and coinsurance amounts satisfied are determined in the MSP payment modules after calculation of the Medicare payment amount.

The "Utilization Days" field of the CWF Record contains the days to be charged to the beneficiary's Medicare utilization record as determined above.

The "Value Code" fields of the CWF Record identify the coinsurance and amount charged the beneficiary as well as an MSP type of primary payer and the primary payer amount.

Value code 44 and the amount are entered on the CWF Record in the appropriate fields (see CWF Documentation). Value code 44 indicates the amount the provider is obligated to accept as payment in full from the primary payer and this amount is greater than the amount paid by the primary payer for Medicare covered services entered by the provider in the identifying primary payer value code.

For the PS&R, the intermediary records the primary payment amount minus any deductible or coinsurance amounts.

50 - MSP Pay Modules to **Calculate M**edicare Secondary Payment Amount

(Rev. 1, 10-01-03)

B3-4306

The MSP Payment Modules are used to calculate the Medicare secondary payment amount. The calculation is based on information from the claim, payment calculation amounts and the primary insurer's explanation of benefits data for hardcopy claims.

The carriers and intermediaries, through the shared systems, send the appropriate data which includes submitted charges, the other payer allowed amount (Part B claims only), the other payer paid amount, the obligated to accept in full (OTAF) amount, and Medicare's fee schedule amount to the MSP payment modules, identified below, to calculate the secondary payment amount.

50.1 - Medicare Secondary Payer (MSP) Payment Modules (MSPPAY) for Carriers

(Rev. 1, 10-01-03)

B3-4306 (Revision 1586 dated 1/98)

A - Introduction

The Part B MSPPAY modules are standardized software contractors must use to calculate the secondary payment amount. This ensures consistent MSP payment calculations. The calculations performed by these modules are in accordance with 42 CFR 411.33. (See Chapter 1, §§10, §§20, and §§30.) Updates to these modules including technical documentation are furnished by CMS, as required.

50.1.1 - Payment Calculation Processes for MSP Claims

(Rev. 1, 10-01-03)

B3-4306.B (Revision 1586 dated 1/98), A3-3697.B

For a valid Medicare secondary payer claim, the Part B MSPPAY module perform the following payment calculation processes:

- Apportions the primary payer's paid amount, the other payer's allowed amount and obligated to accept as payment in full (if applicable), based on the ratio computed by the total amount billed for each service divided by the total billed amount, if line item information is not supplied by the primary payer.

- Computes the Medicare secondary payment amount for assigned and unassigned claims by line; and

- Computes Medicare secondary savings.

50.1.2 - MSPPAY "Driver" Module

(Rev. 1, 10-01-03)

B3-4306.C

The MSPPAY makes the determination based on the service "thru-date" on the claim to call one of the following MSP sub-modules to process the payment calculations.

A - MSPPAYO

Calculates payment for all bill types with service "thru-date" prior to November 13, 1989. It requires the same sending data elements supplied to sub-modules MSPPAY B and MSPPAYAO.

B - MSPPAYB

Calculates payment for Medicare Part B claims with service "thru-date" on or after November 13, 1989. It accepts the limiting charge and the 115 percent limit on fee schedule amounts for nonparticipating physicians for Medicare Part B claims for "thru-dates" on or after April 1, 1998. It calculates payment for Medicare Part B claims by line service with service "thru-dates" on or after April 1, 1998.

C - MSPPAYBL

Accepts data from MSPPAY, if the claim is at the aggregate level, and apportions the primary payer's allowed amount for each service and how much the primary payer paid for each service based on the ratio computed by the amount billed for each service divided by the total billed amount. It calls MSPPAYB to calculate the claim by line.

MSPPAY receives claim data from the contractor's system and does the following:

A - Performs validity edits on the sending field THRU-DATE:

- Century value must be "19" or "20."

- Year value must be "00" thru "99."

- Month value must be "01" thru "12."

- Day value must be "01" thru "31."

B - Performs validity edits on the sending field RECORD-ID:

- HMBC = Part B claim; or,
- HMBL = Part B claim by line;

C - Calls the appropriate MSP payment sub-modules:

- MSPPAYO for claim service THRU-DATE prior to 11/13/89;
- MSPPAYB for claim service THRU-DATE on or after 11/13/89 with RECORD-ID of HMBC; or,
- MSPPAYBL for claim service THRU-DATE on or after 4/1/98 with RECORD-ID HMBL

D - Returns appropriate status codes along with the Medicare secondary payment computation and savings data to the carrier system. See §50.1.3 for an explanation of return codes.

Once MSPPAY passes information to the carrier claims processing system, it can be retrieved in any format desired, e.g., savings reports, management tools, and MSN generation. The reports can be tailored to the carrier specific needs.

50.1.3 - Return Codes

(Rev. 1, 10-01-03)

B3-4306.D

One of the following codes is returned to the carrier system, which indicates the results from processing secondary payment computation and savings. These codes are also referenced in the technical documentation released with the MSPPAY modules.

Return Code	Description
3010	Claim is fully paid
3020	Claim is partially paid
3030	Line of service denied
3500	Invalid MSP value code
3510	Invalid number of other payers
3520	Non-numeric MSP amount

Return Code	Description
3530	MSP amount equals zeros
3540	Invalid record identification
3545	Non-numeric Gramm-Rudmann-Hollings percent
3560	Non-numeric blood deductible
3570	Non-numeric cash deductible
3700	Non-numeric total coinsurance amount
3730	Non-numeric Medicare primary payment
3780	Non-numeric provider payment amount
3790	Non-numeric patient payment amount
3800	Invalid assignment indicator
3805	Invalid par indicator
3810	Non-numeric other payer allowed amount
3820	Non-numeric charges not subject to deductible and coinsurance
3830	Non-numeric charges subject to deductible
3840	Non-numeric psychiatric charges
3880	Invalid "thru-date" of claim
3890	Non-numeric Medicare reasonable charge/fee schedule
3910	Non-numeric obligated to accept
3920	Non-numeric total actual charges
3930	Non-numeric limited fee
3940	Non-numeric limited charge
3950	Limited fee equal zeros
3960	Limited charge equal zeros

50.1.4 - Executing and Testing MSPPAY Software

(Rev. 1, 10-01-03)

B3-4306.E

Carriers receive the MSP software through their standard system along with the Medicare Secondary Payment Technical Manual documenting, and describing the execution of the MSPPAY Module(s). The input data elements and output data elements required are referenced in these manuals. Carriers are responsible for testing the MSPPAY software and reviewing the results.

50.1.5 - Carrier MSPPAY Processing Requirements

(Rev. 1, 10-01-03)

B3-4306.F, **B-03-026**

The following processing requirements apply:

- Process all MSP physician/supplier claims through the MSPPAY software to determine MSP payment amount, at the line level, where applicable, deductible, coinsurance, and savings;

- Claims processed by MSPPAY must be in ready-to-pay status, e.g., the amount that Medicare would have paid as the primary payer, the type of MSP situation, the amount of the primary insurer's payment, information regarding outstanding deductible and coinsurance must be available to MSPPAY; and

- All data elements required by MSPPAY must be passed to it. Section 50.1.7.A lists these data elements. The Medicare Secondary Payment Technical Manual also contains additional information about them.

- The standard systems must accept MSP claims for services at the line level including incoming charges, the OTAF amount, the other payer allowed and paid amounts for incoming MSP claims at the line level.

- Forward the service line level amounts to the MSPPAY Module for payment calculation.

- Receive the MSP payment at the line level when the completed calculations are returned to the system from the MSPPAY module.

50.1.6 - Error Resolution

(Rev. 1, 10-01-03)

B3-4306.G

Carriers are responsible for resolving error conditions reflected as return codes. These return codes are identified in §50.1.3 above and in the Medicare Secondary Payment Technical Manual. It is easier to resolve error conditions by turning on the test switch provided in the software and printing the displays.

After reviewing the displays, any unresolved error conditions and displays should be forwarded to the CMS MSP Coordinator in the carrier's region. The carrier includes any additional documentation that may assist in resolving the error.

50.1.7 - Payment Calculation for Physician/Supplier Claims (MSPPAYB Module)

(Rev. 1, 10-01-03)

B3-4306.1

The MSPPAYB module performs the necessary payment calculation for physician/supplier claims with service "thru-dates" on or after November 13, 1989.

A - Data Elements to send to MSPPAYB

MSPPAY must send the following data elements to MSPPAYB:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software display sending and returning data. Used to identify payment problems.	"T" = display send/return data Space = do not display data.
2	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD)	Supplied by carrier system from Field 24 of the Form CMS-1500
		THRU DATE CC	Value = "19" or "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"

NO.	Field Name	Definition/Use	Source/Value
3	RECORD ID	Identifies the claim type.	Part B = "HMBC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by carrier system from Field 1a of the Form CMS-1500.
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by carrier system.
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by carrier system. Value Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by carrier system Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data	Supplied by carrier system. May occur up to 10 times.
	MSP CODE	Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers" Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Based on information obtained from the Form CMS-1500, Fields 6, 8, 10, 11, or 24; third party-payer information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements.
	MSP AMOUNT	Amount(s) paid by the other payer	Third party payer explanation of benefits

NO.	Field Name	Definition/Use	Source/Value
		payer.	of benefits
9	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	Form CMS-1500, Field 28
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer.	Third party payer explanation of benefits
11	OTHER PAYER ALLOWED AMT.	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
12	MEDICARE REASONABLE CHG & FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by carrier system.
13	FILLER		Nine Value Spaces
14	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
15	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by carrier system.
16	FILLER		Sixty-eight value spaces
17	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by carrier system.
18	FILLER		Six value spaces
19	Assignment Indicator	An indicator that identifies if the claim is assigned or unassigned.	Form CMS-1500, Field 27.One value space
20	FILLER		Twenty-eight value spaces
21	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance	Computed and supplied by carrier system.

NO.	Field Name	Definition/Use	Source/Value
		deductible and coinsurance.	
22	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by carrier system.
23	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by carrier system.
24	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by carrier system.
25	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Compute and supplied by carrier system.
26	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by carrier system.
27	PSYCH CHARGES	Allowed psychiatric charges reduced by the psychiatric percent (62.5% of 80%) but unreduced by coinsurance and deductible (if applicable).	Computed and supplied by carrier system.
28	PAR INDICATOR		Supplied by carrier system "P" = Par Provider "N" = No-Par Provider
29	LIMITED FEE NON-PAR		Computed and supplied by carrier system
30	LIMITED CHARGES UNASSIGNED		Computed and supplied by carrier system

NO.	Field Name	Definition/Use	Source/Value
31	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
32	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B - MSPPAYB Returning Data Elements

MSPPAYB will return the following data elements to MSPPAY. Refer to section A above for field definitions not reflected below.

No.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

No	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to CWF.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF
4	FILLER	Seventy seven value spaces
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
6	FILLER	Nine value spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
8	PROVIDER PAYMENT AMT	
9	PATIENT PAYMENT AMT	

No	Field Name	Definition/Use
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
13	FILLER	Three value spaces
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
15	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.
16	FILLER	Nine value spaces.
17	SAVINGS MSP GHP	Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).
18	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
19	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
20	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
21	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
22	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).

No	Field Name	Definition/Use
23	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
24	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
25	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
26	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.
27	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
28	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
29	MSP COMPUTATION 1	The result of: the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer for covered services.
30	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
31	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed

No	Field Name	Definition/Use
		payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.
32	FILLER	Nine value spaces
33	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)
34	RESERVED FOR USER	Space Reserved for User as Necessary. (153 value spaces)

50.1.8 - Payment Calculation for Physician/Supplier Claims (MSPPAYBL)

(Rev. 1, 10-01-03)

B3-4306.2

The sub-module performs the necessary payment calculation, on a by line basis, for physician/supplier claims with service "thru-dates" on or after April 1, 1998.

A. MSPPAYBL Sending Data Elements.

MSPPAY must send the following data to MSPPAYBL:

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software display sending and returning data. Used to identify payment problems.	"T" = display send/return data; Space = do not display data
2	FILLER		8 value spaces
3	RECORD ID		Identification of Part B type claim being processed = "HMBL"
4	CLMNO	Health Insurance Claim Number	Supplied by the carrier system from Field 1a of the Form CMS-1500.

No.	Field Name	Definition/Use	Source/Value
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the carrier system
6	FILLER		1 value space
7	APPORTION SWITCH	Determine whether to apportion the Other Payer's Allowed Amount and Payment Amount	Supplied by the carrier system "N" = do not apportion Space = do apportion
8	TOTAL ACTUAL CHARGES		Supplied by the carrier system
9	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the carrier system. Valid value '01' thru '10'

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

10	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data. MSP Code - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Worker's Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = Liab (Liability)	Based on information obtained from the Form CMS-1500, (Fields 6, 8, 10, 11, or 24), third party information submitted with the Claim, i.e., explanation of benefits or appropriate electronic data elements. Supplied by the carrier system. May occur up to 10 times.

No.	Field Name	Definition/Use	Source/Value
	MSP AMOUNT	Amount(s) paid by the other payer.	
11	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third Party Payer explanation of benefits
12	NUMBER OF LINES	Number of lines to compute MSP amounts.	Supplied by the carrier system
13	RESERVED FOR CMS	Space reserved for future enhancements.	124 value spaces
14	RESERVED FOR USER	Space reserved for user as necessary.	100 value spaces
15	LINE NUMBER	Line of service number.	Supplied by the carrier system. Values "01" thru "13"
16	DENIED INDICATOR	Indicator that reflects whether Medicare or the other carrier denied the line of service.	Supplied by the carrier system "D" = Line of service denied by the other carrier and/or Medicare. Space = Line of service accepted for payment by the other carrier and/or Medicare.
17	FILLER		One value space
18	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD)	Supplied by the carrier system from Field 24 of the Form CMS-1500
		THRU DATE CC	Value = "19" or "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
19	RECORD ID	Identifies the claim type.	Part B = "HMBL"
20	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the carrier system from Field 1a of the Form CMS-1500

No.	Field Name	Definition/Use	Source/Value
			CMS-1500
21	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the carrier system
22	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the carrier system "Y" = Fully paid by other payer Space = Not fully paid by other payer
23	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the carrier system Valid value "01" thru "10"
24	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data.	Based on information obtained from the Form CMS-1500, (Fields 6, 8,10, 11, or 24). Third party information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements.
25	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Supplied by the carrier system. May occur up to 10 times

No.	Field Name	Definition/Use	Source/Value
26	MSP AMOUNT	Amount(s) paid by the other payer.	Third party payer explanation of benefits
27	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	Form CMS-1500, Field 28
28	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer.	Third party payer explanation of benefits
29	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
30	MEDICARE REASONABLE CHG &FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by the carrier system.
31	FILLER		Nine value spaces
32	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
33	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by the carrier system.
34	FILLER		Sixty-eight value spaces
35	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the carrier system.
36	FILLER		Six value spaces

No.	Field Name	Definition/Use	Source/Value
37	ASSIGNMENT INDICATOR	An indicator that identifies if the claim is assigned or unassigned.	Form CMS-1500, Field 27 One value space "A" = Assigned claim "B" = Non-assigned claim
38	FILLER		Twenty eight value spaces
39	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the carrier system.
40	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the carrier system.
41	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the carrier system.
42	G-R-H PERCENT (GRAMM-RUDMANN - HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the carrier system.
43	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the carrier system.
44	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the carrier system.
45	PSYCH CHARGES	Allowed psychiatric charges reduced by the psychiatric percent (62.5% of 80%) but unreduced by coinsurance and deductible (if applicable).	Computed and supplied by the carrier system.

No.	Field Name	Definition/Use	Source/Value
46	PAR INDICATOR	Indicator reflecting whether the provider participates in the Medicare program.	Supplied by the carrier system. "P" = Par Provider "N" = Non-Par Provider
47	LIMITED FEE NON-PAR	The fee amount paid to a nonparticipating provider.	Computed and supplied by the carrier system.
48	LIMITED CHARGES UNASSIGNED	The charge for each service on unassigned claims.	Computed and supplied by the carrier system if LC on Form CMS-1500 exceeds more than 115% of Medicare fee schedule amount.
49	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
50	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B - MSPPAYBL Returning Data Elements.

MSPPAYBL will return the following data to MSPPAY:

No	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
2	HEADER OR LINE ERROR	Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYBL: "H" = Header Error "L" = Line Error

No	Field Name	Definition/Use
3	LINE NUMBER OF ERROR	Reflects the line of service an error was detected.
4	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).
5	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF
6	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File.
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
8	PROVIDER PAYMENT AMT	
9	PATIENT PAYMENT AMT	
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.

No	Field Name	Definition/Use
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
13	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
14	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).
15	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
16	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
17	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
18	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
19	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
20	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
21	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
22	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).

No	Field Name	Definition/Use
23	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.
24	RESERVED FOR CMS	Space reserved for future enhancements. (123 value spaces)
25	RESERVED FOR USER	Space reserved for user as necessary. (118 value spaces)

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

26	LINE NUMBER	Line of service number
27	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.

NOTE: The Source/Value is determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

28	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the CWF
29	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF.
30	FILLER	(77 value spaces)
31	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
32	FILLER	(9 value spaces)
33	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
34	PROVIDER PAYMENT AMT	Reimbursement paid to the provider.
35	PATIENT PAYMENT AMT	Reimbursement paid to the patient.

No	Field Name	Definition/Use
36	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.
37	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
38	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
39	FILLER	(3 value spaces)
40	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
41	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.
42	FILLER	(36 value spaces)
43	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).
44	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
45	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
46	SAVINGS MSP WORK	Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).
47	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
48	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).

No	Field Name	Definition/Use
49	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
50	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
51	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
52	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.
53	FILLER	Eighteen value spaces
54	MSP COMPUTATION 1	The result of the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full, if that is less than the charges, minus the amount paid by the primary payer for covered services.
55	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
56	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.
57	FILLER	Nine value spaces
58	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)
59	RESERVED FOR USER	Space reserved for user as necessary. (153 value spaces)

50.2 - Medicare Secondary Payer (MSP) Payment Modules (MSPPAY) for Intermediaries

(Rev. 1, 10-01-03)

A3-3697

A - Introduction

The Part A MSPPAY modules are standardized software contractors must use to calculate MSP bill payment. This ensures consistent MSP payment calculations. The calculations performed by these modules are in accordance with regulations 42 CFR 411.33. (See Chapter 1, §10.8 and this chapter, §30.3.1, and §30.5. Updates to these modules including technical documentation are furnished by CMS, as required.

50.2.1 - Payment Calculation Processes for MSP Claims

(Rev. 1, 10-01-03)

A3-3697

The following payment calculation processes are performed for a valid Medicare secondary payer bill.

- Apportions the primary payer's paid amount and obligated to accept as payment in full (if applicable), for outpatient services, based on the ratio computed by the Total Medicare Covered Charges for each service line divided by the Total Medicare Covered Charges;
- Computes the Medicare secondary payment amount, applicable deductible, and coinsurance amounts;
- Reduces benefit utilization (if applicable); and
- Computes Medicare secondary savings.

MSPPAY is the "driver" module in the above processes.

50.2.2 - MSPPAY "Driver" Module

(Rev. 1, 10-01-03)

A3-3697.C

MSPPAY, the "Driver Module," makes the determination based on the service "thru-date" on the bill to call one of the following MSP sub-modules to process the payment calculations:

A - MSPPAYO

MSPPAYO calculates payment for all bill types with service ""thru-dates"" prior to November 13, 1989. It requires the same sending data elements supplied to sub-modules MSPPAYAI (See §50.2.7) and MSPPAYAO. (See §50.2.2.)

B - MSPPAYAI

MSPPAYAI calculates payment for inpatient, skilled nursing facility (SNF), and religious nonmedical health care (RNHC) bill types with service ""thru-dates"" on or after November 13, 1989. (See §50.2.7.)

C - MSPPAYOL

MSPPAYOL calculates payment at the service line level for outpatient bill types with service "thru-date" on or after November 13, 1989. (See §50.2.8). Accepts data from MSPPAY and apportions the primary payer's paid amount and obligated to accept as payment in full (if applicable) based on the ratio computed by the Total Medicare Covered Charges for each service line divided by the Total Medicare Covered Charges. It calls MSPPAYAO to calculate the claim by line.

D - MSPPAYAO

MSPPAYAO calculates payment for outpatient, home health agency (HHA), and hospice bill types with service "thru-dates" on or after November 13, 1989. (See §50.2.9.)

MSPPAY receives bill data from the contractor's system and performs the following processes:

A - Performs validity edits on the sending field "THRU-DATE"

- Century value must be "19" or "20"
- Year value must be "00" thru "99."
- Month value must be "01" thru "12."
- Day value must be "01" thru "31."

B - Performs validity edits on the sending field RECORD-ID

- HMIP = Inpatient/SNF/CSS bills
- HMOL = Outpatient claims by line
- HMOP = Outpatient bills
- HMHH = Home health bills

- HMHC = Hospice claim

C - Calls the appropriate MSP payment sub-modules

- MSPPAYO for bill service THRU-DATE prior to 11/13/89;
- MSPPAYAI for bill service THRU-DATE on or after 11/13/89 with RECORD-ID of HMIP; and
- MSPPAYAO for bill service THRU-DATE on or after 11/13/89 with RECORD-ID of HMOP, HMHH, or HMHC
- MSPPAYOL for claim service THRU-DATE on or after 11/13/89 with RECORD-ID of HMOL

D - Returns appropriate status codes along with the MSP computation and savings data to the intermediary system

See §50.2.3 below for an explanation of return codes.

Once MSPPAY passes back information to the intermediary claims processing system, the data can be retrieved in any format desired, e.g., savings reports, management tools, and MSN generation. The reports can be tailored to the intermediary's specific needs.

50.2.3 - Return Codes

(Rev. 1, 10-01-03)

A3-3697.D

One of the following codes which indicates the results from processing secondary payment computation and savings is returned to the intermediary system. These codes are also referenced in the technical documentation released with the MSPPAY modules.

Return Code	Description
3010	Claim is fully paid
3020	Claim is partially paid
3030	Line of service denied
3500	Invalid MSP value code
3510	Invalid number of other payers
3520	Non-numeric MSP amount

3530	MSP amount equals zeros
3540	Invalid record identification
3545	Non-numeric Gramm-Rudmann-Hollings percent
3550	Non-numeric total covered charges
3560	Non-numeric blood deductible
3570	Non-numeric cash deductible
3700	Non-numeric total coinsurance amount
3730	Non-numeric Medicare primary payment
3780	Non-numeric provider payment amount
3790	Non-numeric patient payment amount
3820	Non-numeric charges not subject to deductible and coinsurance
3830	Non-numeric charges subject to deductible
3850	Invalid from date of claim
3880	Invalid "thru-date" of claim
3900	Non-numeric Medicare payment amount
3910	Non-numeric obligated to accept
3580	Non-numeric regular coinsurance days 1st year
3590	Non-numeric regular coinsurance rate 1st year
3600	Non-numeric regular coinsurance amount 1st year
3610	Non-numeric regular coinsurance days 2nd year
3620	Non-numeric regular coinsurance rate 2nd year
3630	Non-numeric regular coinsurance amount 2nd year
3640	Non-numeric life-time reserve days 1st year
3650	Non-numeric life-time reserve rate 1st year
3660	Non-numeric life-time reserve amount 1st year

3670	Non-numeric life-time reserve days 2nd year
3680	Non-numeric life-time reserve rate 2nd year
3690	Non-numeric life-time reserve amount 2nd year
3710	Non-numeric full days
3720	Non-numeric covered days
3740	Invalid PPS indicator
3750	Non-numeric DRG amount
3760	Non-numeric direct graduate medical education
3770	Non-numeric pass thru per diem amount

50.2.4 - Installation

(Rev. 1, 10-01-03)

A3-3697.E

Intermediaries receive the MSP software through the standard systems along with the Medicare Secondary Payment technical manuals documenting and describing installation and execution of the MSPPAY module(s). The input data elements and output data elements required are referenced in these manuals. Intermediaries are responsible for testing and verifying the accuracy of the MSPPAY software when updates are implemented.

50.2.5 - Intermediary Processing Requirements

(Rev. 1, 10-01-03)

A3-3697.F

The following processing requirements apply:

- The intermediary processes all MSP inpatient hospital, SNF, HHA bills through the MSPPAY software to determine MSP payment amount, deductible, coinsurance, and savings.

- The intermediary processes all MSP outpatient bills through the MSPPAY software, at the line level, to determine MSP payment amount, deductible, coinsurance, and savings.

- Bills processed by MSPPAY must be in ready-to-pay status, e.g., the amount that Medicare would have paid as the primary payer, the type of MSP situation, the amount of the primary insurer's payment, information regarding outstanding deductible and coinsurance must be available to MSPPAY; and

- All data elements required by MSPPAY must be passed to it. Sections 50.2.7.A and 50.2.8.A list these data elements. The Medicare Secondary Payment Technical manuals also contain additional information about them.

50.2.6 - Error Resolution

(Rev. 1, 10-01-03)

A3-3697.G

Intermediaries are responsible for resolving error conditions reflected as return codes. These return codes are identified in §50.2.3 above and in the Medicare Secondary Payment Technical manuals. It is easier to resolve error conditions by turning on the test switch provided in the software and printing the displays.

After reviewing the displays, if the intermediary is still unable to resolve an error condition, it forwards these displays to the CMS MSP Coordinator in its region. It includes any additional documentation that may assist in resolving the error.

50.2.7 - Payment Calculation for Inpatient Bills (MSPPAYAI Module)

(Rev. 1, 10-01-03)

A3-3697.1, A3 - 3697.1A

MSPPAYAI performs the necessary payment calculation for inpatient, skilled nursing facility (SNF), and Religious Nonmedical Health Care (RNHC) bills with service dates on or after November 13, 1989.

A - Data Elements to send to MSPPAYAI

MSPPAY must send the following data elements to MSPPAYAI

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Use to identify payment errors.	"T" = display send/return data; Space = do not display data.

No.	Field Name	Definition/Use	Source/Value
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD)	Supplied by the intermediary system from form locator 42 of the Form CMS-1450 (UB-92)
		THRU DATE CC	Value = "19" thru "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Inpatient (including SNF/CSS) bills = "HMIP"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the intermediary system from form locator 60B of the Form CMS-1450 (UB-92)
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the intermediary system
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the intermediary system. Can be identified by an "O" frequency indicator in Field 4 of the Form CMS-1450 (UB-92). Also identified by condition code "77" in form locators 24-30 of the Form CMS-1450 (UB-92). Value Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the intermediary system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code and MSP amount comprise primary payer data.	Supplied by the intermediary system. May occur up to 10 times.

No.	Field Name	Definition/Use	Source/Value
	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Form CMS-1450 (UB-92), form locators 39-41 (Value codes 12-16 and 41-47)
	MSP AMOUNT	Amount(s) paid by the other payer.	Form CMS-1450 (UB-92) form locators 39-41 (Value amounts)
9	TOTAL COVERED CHARGES	Total charges covered by Medicare	Form CMS-1450 (UB-92) form locator 47
10	OBLIGATED TO ACCEPT	The amount a provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" appears on the bill. It is reported in addition to the MSP Code(s) and MSP amounts(s) and the total covered charges on the bill.	Form CMS-1450 (UB-92), form locators 39-41 Value Code "44"

No.	Field Name	Definition/Use	Source/Value
11	FILLER		Eighteen value spaces.
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the intermediary system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	Form CMS-1450 (UB-92) form locators 39-41, Value Code 06
14	CASH DEDUCTION	Dollar amount of cash deductible charged by Medicare.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 07
15	REG COIN DAYS 1ST YR	Medicare coinsurance days charged in the year of admission.	Computed and supplied by the intermediary system based on information obtained from CMS 1450 (UB-92), form locator 9
16	REG COIN RATE 1ST YR.	The Medicare coinsurance rate charged in the year of admission.	Computed and supplied by the intermediary system.
17	REG COIN AMT 1ST YR	The Medicare coinsurance amount charged in the year of admission.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 09
18	REG COIN DAYS 2ND YR	Medicare coinsurance days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the intermediary system.
19	REG COIN RATE 2ND YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the intermediary system.
20	REG COIN AMT 2ND YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
21	LTR COIN DAYS 1ST YR	Medicare lifetime reserve days charged in the year of admission.	Computed and supplied by the intermediary system.

No.	Field Name	Definition/Use	Source/Value
22	LTR COIN RATE 1ST YR	The Medicare lifetime reserve rate charged in the year of admission.	Computed and supplied by the intermediary system.
23	LTR COIN AMT 1ST YR	The Medicare lifetime reserve amount charged in the year admission.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 08
24	LTR COIN DAYS 2ND YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the intermediary system.
25	LTR COIN RATE 2ND YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the intermediary system.
26	LTR COIN AMT 2ND YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
27	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the intermediary system.
28	FULL DAYS	The inpatient Medicare days occurring in the first 60 days in a single spell of illness.	Computed and supplied by the intermediary system.
29	COVERED DAYS	The number of Medicare covered days.	Form CMS-1450 (UB-92) form locator 7
30	FILLER		One value space
31	PPS IND	An indicator that identifies a prospective payment provider.	Supplied by intermediary system: X = PPS S = CSS (non-PPS), Spaces = non-PPS

No.	Field Name	Definition/Use	Source/Value
32	DRG AMOUNT	Total prospective payment amount including any outlier payment, as determined by Pricer.	Computed by Pricer and supplied by the intermediary system
33	DIRECT GRADUATE MEDICAL EDUCATION	Estimated adjustment for the direct graduate medical education activities (See 42 CFR 413.86.)	Computed and supplied by the intermediary system.
34	PASS THRU PER DIEM	Payment amount for those items that are reimbursed on a reasonable cost basis.	Computed and supplied by the intermediary system.
35	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the intermediary system.
36	PROVIDER PAYMENT AMOUNT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the intermediary system.
37	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the intermediary system.
38	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the intermediary system.
39	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the intermediary system.
40	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the intermediary system.

No.	Field Name	Definition/Use	Source/Value
41	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety eight value spaces.
42	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value Spaces

B - Data Elements returned from MSPPAYAI

MSPPAYAI will return the following data elements to MSPPAY. Refer to §50.2.7 for field definitions not reflected below.

NO.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAI. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical documentation released with the software.

Unless specified otherwise, MSPPAY is the source of all the following fields, possibly modified by MSPPAYAI.

NO.	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF).
4	REG COIN DAYS 1ST YR	
5	REG COIN RATE 1ST YR	
6	REG COIN AMT 1ST YR	
7	REG COIN DAYS 2ND YR	
8	REG COIN RATE 2ND YR	
9	REG COIN AMT 2ND YR	
10	LTR COIN DAYS 1ST YR	

NO.	Field Name	Definition/Use
11	LTR COIN RATE 1ST YR	
12	LTR COIN AMT 1ST YR	
13	LTR COIN DAYS 2ND YR	
14	LTR COIN RATE 2ND YR	
15	LTR COIN AMT 2ND YR	
16	PART A REG COIN DAYS	The total Medicare coinsurance days chargeable to the beneficiary.
17	PART A LTR COIN DAYS	The total Medicare lifetime reserve days chargeable to the beneficiary.
18	PARTA COIN DAYS	The total Medicare coinsurance and lifetime reserve days chargeable to the beneficiary.
19	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File (CWF).
20	FULL DAYS	The number of inpatient Medicare days occurring in the first 60 days in a single spell of illness.
21	UTILIZED DAYS	Days of care that are chargeable to Medicare
22	COST REPORT DAYS	Days credited to the provider's PS&R as Medicare days.
23	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
24	PROVIDER PAYMENT AMT	
25	PATIENT PAYMENT AMT	
26	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.

27	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
28	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
29	MSP COVERED DAYS	The number of days covered by the primary payer.
30	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
31	GROSS MEDICARE PAYMENT	The amount Medicare pays excluding deductibles and coinsurance. (For PPS claims, direct graduate medical education and pass-thru amounts are included.)
32	MSP NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed at 100%is not reflected in this figure. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
33	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)
34	FILLER	Nine Value spaces.
35	PPS CREDIT AMOUNT	The excess of the MSP amount over the DRG amount.

36	SAVINGS MSP EGHP	Amount saved by Medicare when an EGHP has made a payment for a working aged beneficiary (MSP Code 12).
37	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
38	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
39	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
40	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
41	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
42	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
43	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
44	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
45	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.

46	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
47	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, 42, and 43. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
48	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.
49	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
50	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.
51	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.
52	RESERVED FOR CMS	Space reserved for future enhancements. (200 Value Spaces)
53	RESERVED FOR USER	Space reserved for user as necessary. (153 Value Spaces)

50.2.8 - Payment Calculation for Outpatient Claims (MSPPAYOL)

(Rev. 1, 10-01-03)

A3-3697.2

MSPPAYOL performs the necessary payment calculation, on a line-by-line basis, for outpatient claims with service "thru-dates" on or after November 13, 1989.

A - MSPPAYOL Sending Data Elements

MSPPAY must send the following data elements to MSPPAYOL:

No.	Field Name/Definition/Use	Source/Value
	(H) = Claim Header	
1.	TEST SWITCH (H) Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	"T" = display send/return data space = do not display data
2.	FILLER	Value spaces
3.	RECORD ID (H) Identifies the bill type	Part A Outpatient by line - "HMOL"
4.	CLMNO (H) Health Insurance Claim Number	Supplied by the intermediary system from Field 60B of the Form CMS-1450 (UB-92)
5.	DOC CNTL NUM (H) Assigned document control number	Assigned and supplied by the intermediary system
6.	FILLER	Value space

No.	Field Name/Definition/Use	Source/Value
7.	APPORTION SWITCH (H)	Supplied by the intermediary system to determine whether to apportion the Other Payer's Payment Amount and Obligated To Accept (if applicable): "N" = Do not apportion Space = do apportion
8.	TOTAL COVERED CHARGES (H)	Supplied by the intermediary system
9.	NUM OTHER PAYERS (H) The number of other payers who are primary to Medicare	Supplied by the intermediary system Valid value "01" thru "10"
10.	THIRD PARTY PAYER TABLE (H) MSP CODE (H) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) MSP AMOUNT (H) - Amounts paid by the other payer	Supplied by the intermediary system May occur up to 10 times. Form CMS-1450 (UB-92), Fields 39-41 (Value codes 12-16 and 41-47)

No.	Field Name/Definition/Use	Source/Value
11.	OBLIGATED TO ACCEPT	Form CMS-1450 (UB-92)
	Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	Value Code "44"
12.	NUMBER OF LINES (H) - of lines to compute MSP amounts	Supplied by the intermediary system
13.	RESERVED FOR CMS (H)	76 value spaces
14.	RESERVED FOR USER (H)	75 value spaces
	(L) CLAIM LINE	
	NOTE: THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	
15.	LINE NUMBER (L)	Supplied by the intermediary system
	Line of service number.	Values "01" thru "450"
16.	BYPASS INDICATOR (L)	Supplied by the intermediary system
		"B" = Line of service to be bypassed by the software.
		Space = Line of service not bypassed by the software.
17.	DENIED INDICATOR (L)	Supplied by the intermediary system
		"D" = Line of service denied by the Other Payer.
		Space = Line of service accepted for payment by the Other Payer.

No.	Field Name/Definition/Use	Source/Value
18.	THRU DATE (L)	Supplied by the intermediary system
	THRU DATE CC (L)	Value = "19" or "20"
	THRU DATE YY (L)	Value = "00" thru "99"
	THRU DATE MM (L)	Value = "01" thru "12"
	THRU DATE DD (L)	Value = "01" thru "31"
19.	FULLY PAID CLAIM IND (L)	Supplied by the intermediary system
	Indicator that reflects line is fully paid by the third party payer	"Y" = Fully Paid by Other Payer Space = Not Fully Paid by Other Payer
20.	NUM OF OTHER PAYERS (L)	Supplied by the intermediary system
	The number of other payers who are primary to Medicare.	Value "01" thru "10"
21.	THIRD PARTY PAYER TABLE (L)	Supplied by the intermediary system May occur up to 10 times.
	MSP CODE (L) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Form CMS-1450 (UB-92), Fields 39-41 (Value codes 12-16 and 41-47)
	MSP AMOUNT (L) - Amounts paid by the other payer	

No.	Field Name/Definition/Use	Source/Value
22.	TOTAL COVERED CHARGES (L) Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	Supplied by the intermediary system
23.	OBLIGATED TO ACCEPT (L) Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	Form CMS-1450 (UB-92) Value Code "44" Apportioned by MSPPAY Software
24.	MED PAYMENT AMOUNT (L) Medicare payment without regard to deductibles and coinsurance	Supplied by the intermediary system
25.	BLOOD DEDUCTION (L) Dollar amount of blood deductible charged by Medicare.	Form CMS-1450 (UB-92) Fields 39-41, Value Code 06
26.	CASH DEDUCTION (L) Dollar amount of deductible charged by Medicare.	Form CMS-1450 (UB 92) Fields 39-41, Value code 07

No.	Field Name/Definition/Use	Source/Value
27.	TOTAL COIN AMT (L) The Total Coinsurance amount chargeable to the beneficiary	Computed and Supplied by the intermediary system.
28.	MED PRIMARY PAYMENT (L) The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the intermediary system
29.	PROVIDER PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the intermediary system
30.	PATIENT PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the intermediary system
31.	G-R-H PERCENT (L) (GRAMM-RUDMANN-HOLLINGS) The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the intermediary system
32.	CHARGES NSDC (L) CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE) - Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the intermediary system
33.	CHARGES SD (L) (CHARGES SUBJECT TO DEDUCTIBLE) Charge amount subject to the deductible.	Computed and supplied by the intermediary system
34.	PPS IND (L) - An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B - MSPPAYOL Returning Data Elements

MSPPAYOL will return the following data elements to MSPPAY.

No.	Field Name/Definition/Use	Source/Value
	(H) CLAIM HEADER	
1.	RETURN CODE (H) Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYOL Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2.	HEADER OR LINE ERROR (H) Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYOL "H" = Header Error "L" = Line Error
3.	LINE NUMBER OF ERROR (H) Reflects the line of service an error was detected.	
4.	BLOOD DEDUCTION TO CWF (H) Amount of blood deductible to report to the Common Working File (CWF).	
5.	CASH DEDUCTION TO CWF (H) Dollar amount of deductible to report to the CWF.	
6.	TOTAL COIN AMT TO CWF (H) - The total coinsurance amount to report to the CWF.	
7.	MED SECONDARY PAYMENT (H) - Medicare's secondary payment computed by the MSP software.	
8.	PROVIDER PAYMENT AMT (H) -	

No.	Field Name/Definition/Use	Source/Value
9.	PATIENT PAYMENT AMT (H)	
10.	BLOOD DEDUCTION TO CHG (H) The amount of blood deductible the beneficiary may be charged by the provider.	
11.	CASH DEDUCTION TO CHG (H) - The dollar amount of deductible the beneficiary may be charged by the provider	
12.	TOTAL COIN AMT TO CHG (H) - The total coinsurance amount chargeable to the beneficiary	
13.	G-R-H SAVINGS REDUCTION (H) - (Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
14.	GROSS MEDICARE PAYMENT (H) The amount Medicare pays excluding deductibles and coinsurance.	
15.	MSP PYMT SDC (H) The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure.	

No.	Field Name/Definition/Use	Source/Value
	(This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
16.	PSR AMOUNT (H) The primary payer amount used in the Provider Statistical Report System	
17.	SAVINGS MSP GHP - Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
18.	SAVINGS MSP ESRD - Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	
19.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
20.	SAVINGS MSP WORK -Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
21.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
22.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor. (MSP Code 41).	
23.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	

No.	Field Name/Definition/Use	Source/Value
24.	SAVINGS MSP DSAB - Amount saved by Medicare when a LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
25.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
26.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
	(L) CLAIM LINE	
	NOTE: THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	
27.	LINE NUMBER - Line of service number.	
28.	RETURN CODE - Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" See §50.2.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
29.	BLOOD DEDUCTION TO CWF - Amount of blood deductible to report to the CWF	
30.	CASH DEDUCTION TO CWF - Dollar amount of deductible to report to the CWF.	
31.	TOTAL COIN AMT TO CWF - The total coinsurance amount to report to the CWF.	

No.	Field Name/Definition/Use	Source/Value
32.	MED SECONDARY PAYMENT - Medicare's secondary payment computed by the MSP software.	
33.	PROVIDER PAYMENT AMT - Reimbursement paid to the provider.	
34.	PATIENT PAYMENT AMT - reimbursement paid to the patient.	
35.	BLOOD DEDUCTION TO CHG - The amount of blood deductible the beneficiary may be charged by the provider.	
36.	CASH DEDUCTION TO CHG - The dollar amount of deductible the beneficiary may be charged by the provider.	
37.	TOTAL COIN AMT TO CHG - The total coinsurance amount chargeable to the beneficiary.	
38.	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION - The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
39.	GROSS MEDICARE PAYMENT - The amount Medicare pays as primary excluding deductibles and coinsurance.	
40.	SAVINGS MSP GHP - Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).	
41.	SAVINGS MSP ESRD - Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	

No.	Field Name/Definition/Use	Source/Value
42.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
43.	SAVINGS MSP WORK - Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).	
44.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
45.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
46.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
47.	SAVINGS MSP DSAB - Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
48.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
49.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	

No.	Field Name/Definition/Use	Source/Value
50.	MSP COMPUTATION 1 - The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
51.	MSP COMPUTATION 2 - The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.	
52.	MSP COMPUTATION 3 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.	
53.	MSP COMPUTATION 4 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.	

50.2.8.1 – MSPPAY Update to Apportion Prospective Payment System (PPS) Outlier Amounts to All Service Lines with Potential Outlier Involvement

(Rev. 1, 10-01-03)

A-03-006

Prior to the intermediary software release of July 2003, MSPPAY and MSPPAYOL performed MSP calculations at the service line level and did not calculate claims involving a claim level outlier amount. With the software release of July 2003, changes were made to the MSPPAY module so that intermediaries no longer send home health (HH) and outpatient (OP) PPS MSP claims to MSPPAY sub-module MSPPAYPS but will send claims to a modified sub-module MSPPAYOL.

MSPPAYOL is being modified to: (1) accept OPPS and HHPPS MSP claims at the Ambulatory Payment Classification (APC), Home Health Resource Groups (HHRG) and line levels, and (2) apportion OPPS and HHPPS outlier amounts, when greater than zero, to all service lines that are PRICER-related and potential outlier service lines, that is, all

service lines sent to the PRICER and returned with a reimbursement. When MSP claims are received, intermediaries must send the claim outlier amount received from the prospective payment PRICER systems to the MSPPAY software. The standard system must set an indicator of "O" for any APC or HHRG amount that includes a PRICER reimbursement. The indicator will enable MSPPAYOL to determine which service amounts the outlier should apply. MSPPAYOL will take into consideration the outlier amount, if available, and then apportion the outlier amount to the PRICER-related service lines before calculating Medicare's secondary payment. The subsequent service line level calculation will account for the apportioned outlier amount resulting in a single payment amount for each PRICER-related service line. MSPPAY will return the calculated MSP payment amounts to the standard system along with an informational field reporting the apportioned outlier used to calculate payment for that line item service or group of services. The modifications to MSPPAYOL will allow for the service lines on the provider Remittance Advice (RA) to balance, but the informational apportioned outlier amount will not be shown on the RA. The modifications will also result in the line level MSP payment amounts being correctly reported on the PS&R Report. If providers request Medicare adjust or reprocess HHPPS and OPPS MSP claims originally processed prior to July 1, 2003, intermediaries must send these claims to MSPPAYOL.

A – Updating MSPPAYPS

The CMS is making two modifications to MSPPAYPS as follows:

1 - MSPPAYPS is currently returning provider and beneficiary reimbursement amounts at the claim level to the standard system. MSPPAYPS is being modified to return provider and beneficiary line level reimbursement amounts to the standard system.

2 - Prior to July 2003, MSPPAY calculates Outpatient PPS and Home Health PPS MSP claims at the claim level. MSPPAYPS calculates and apportions the Medicare secondary payment to each line that has gross Medicare reimbursement based upon a ratio of each line's gross Medicare reimbursement to the total line's reimbursement. Although the claim level reimbursement amount is correct, the line level amounts do not always total to the claim level amount due to MSPPAYPS' rounding the service line amounts when apportioning. Some service line payment amounts are off by several cents, which causes the remittance advice to be out of balance. MSPPAY is being modified so that service line payment amounts total to the claim level amount.

Although MSPPAYPS will no longer be used to process OPPS and HHPPS MSP claims, CMS will retain the sub-module for circumstances where Medicare is required to process MSP claims under MSPPAYPS resulting from a court order, litigation or change to federal regulations. The standard system must add a field where an indicator can be set that tells the standard system to redirect these types of claims to MSPPAYPS instead of the MSPPAYOL sub-module.

50.2.9 - Payment Calculation for Outpatient Bills (MSPPAYAO Module)

(Rev. 1, 10-01-03)

A3-3697.3

MSPPAYO performs the necessary payment calculation for outpatient, home health, and hospice bills with service "thru-dates" on or after November 13, 1989.

A - MSPPAYAO Sending Data Elements

MSPPAY, or MSPPAYOL, when the claim is calculated to the line level, must send the following data elements to MSPPAYAO:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	T = display send/return data; Space = do no display data.
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD)	Supplied by the intermediary system from Field 42 of the Form CMS-1450 (UB-92)
		THRU DATE CC	Value = "19" thru "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Outpatient = "HMOP" Home health = "HMHH" Hospice = "HMHC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the intermediary system from Field 60B of the Form CMS-1450 (UB-92).
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by the intermediary system.

NO.	Field Name	Definition/Use	Source/Value
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the intermediary system. Can be identified by a "0" frequency indicator in field 4 of the Form CMS-1450 (UB-92). Also identified by condition code "77" in fields 24-30 of the Form CMS-1450 (UB-92). Value Y = Fully paid by other payer. Space = Not fully paid by other payer.
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the intermediary system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE MSP AMOUNT	MSP code(s) and MSP amount comprise third party data. MSP CODE - Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) Amount(s) paid by the other payer.	Supplied by the intermediary system. May occur up to 10 times. Form CMS-1450 (UB-92), Fields 39-41(value codes 12-16 and 41-47)

NO.	Field Name	Definition/Use	Source/Value
9	TOTAL COVERED CHARGES	Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	Form CMS-1450 (UB-92), Fields 39-41 (Value amount)
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full, when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" appears on the bill. It is reported in addition to the MSP amount(s), and the total covered charges on the bill.	Form CMS-1450 (UB-92) Value Code "44"
11	FILLER		Eighteen value spaces
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the intermediary system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	Form CMS-1450 (UB-92) Fields 39 - 41, Value Code 06
14	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Form CMS-1450 (UB-92) Fields 39 - 41, Value Code 07
15	FILLER		Sixty-eight value spaces
16	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the intermediary system.
17	FILLER		Six value spaces
18	FILLER		Twenty-nine value spaces
19	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the intermediary system.

NO.	Field Name	Definition/Use	Source/Value
20	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the intermediary system.
21	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the intermediary system.
22	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the intermediary system.
23	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the intermediary system.
24	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the intermediary system.
25	FILLER		Nine value spaces.
26	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety-eight value spaces.
27	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value spaces.
28	PPS IND	An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B - MSPPAYAO Returning Data Elements

A3 - 3697.3.B

MSPPAYAO will return the following data elements to MSPPAYOL when the claim is calculated to the line level for outpatient claims. Refer to §50.2.7.B for field definitions not reflected below.

No.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).	Unless otherwise specified, MSPPAY is the source of all the following, possibly modified by MSPPAYAI.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF)	
4	FILLER		Seventy-seven value spaces.
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File	
6	FILLER		Nine Value Spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.	
8	PROVIDER PAYMENT AMT		
9	PATIENT PAYMENT AMT		

No.	Field Name	Definition/Use	Source/Value
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
13	FILLER	Three value spaces.	
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	(Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
15	GROSS MEDICARE PAYMENT (H)	The amount Medicare pays excluding deductibles and coinsurance.	
16	NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed by 100% is not reflected in this figure. (This field is only returned for claims with services "thru-dates" prior to 11/13/89)	

No.	Field Name	Definition/Use	Source/Value
17	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT," reflects the total primary payer amount. The primary payer amount designated to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
18	PS&R AMOUNT	The primary payer amount used in the Provider Statistical Report System.	
19	FILLER	Nine value spaces.	
20	SAVINGS MSP EGHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
21	SAVINGS MSP ESRD	Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	

No.	Field Name	Definition/Use	Source/Value
22	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
23	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
24	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
25	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been dame by the Department of Labor (MSP Code 41).	
26	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code42).	
27	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
28	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
29	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payers(s) has made some payment. Includes all MSP codes 12-16, 41- 43 and 47.	

No.	Field Name	Definition/Use	Source/Value
30	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41 and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.	
31	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
32	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
33	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts	
34	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full if that is less than the charges), minus the amount paid by the primary payer	

No.	Field Name	Definition/Use	Source/Value
35	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts	
36	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)	
37	RESERVED FOR USER	Space reserved for user as needed. (153 value spaces)	

50.3 – Multiple Primary Payer Amounts For a Single Service

AB-03-011

A - Intermediary Instructions

Sometimes more than one primary payer makes payment on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. Shared system changes must be made, as necessary, so contractors can:

1) Identify electronic incoming MSP claims with multiple primary payers;

2) Send each claim level MSP value code, other than Value Code 44, paid amount found on the primary payer's MSP claim through the shared system so MSPPAY can calculate Medicare's secondary payment; and

3) Identify the lowest obligated to accept as payment in full (OTAF) amount, which is identified by Value Code 44 and send that amount to MSPPAY (**NOTE:** MSPPAY will use Medicare covered charges if covered charges are lower than the OTAF amount).

B – Multiple Primary Payers

Providers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Institutional Implementation Guide regarding the submission of Medicare beneficiary claims when there are multiple primary payers. Providers must follow model 1 in Section 1.4.2.1, which discusses the "provider to payer to provider" methodology of submitting claims. When multiple payer claim information is attached to the inbound 837, your shared system must be able to identify these types of claims and do the following:

1) Primary Payer Paid Amounts: Identify Primary Payer information from loop 2300, qualifier HIXX-1=BE. The value codes found in HIXX-2 and the value code monetary amounts found in HIXX-5 must be sent to MSPPAY by the shared system.

2) OTAF: Take the lowest Value Code 44 (the OTAF) amount, which must be greater than zero, found in loop 2300 segment HI, and send that amount to MSPPAY. **NOTE**: A value of "Y," in loop 2320, segment OI03, indicates there is an OTAF amount in loop 2300 segment HI.

C – Part A Hardcopy MSP Claims

When an intermediary receives a hardcopy MSP claim, they take the Value Code paid amounts, found in FL 39-41 of the Form UB 92/1450 and send these amounts to MSPPAY. If more than one Value Code 44 is received on the claim, these value codes must be keyed and sent to the shared system. The shared system must take the lowest Value Code 44 amount found on the claim and send it to MSPPAY.

D – Claim Example

Below is an example of a Part A MSP claim sent to an intermediary. All services are Medicare covered services. The following OTAF and other Payer Paid Amounts are sent to MSPPAY at the claim level. The other Payer Paid Amounts (below) may be calculated and sent by line for non-OPPS CELIP claims

Payer 1	**Submitted Covered Charges**		**OTAF**	**Other Payer Paid Amount**
Total	**$150.00**		**$80.00**	**$70.00**

Payer 2	**Submitted Covered Charges**		**OTAF**	**Other Payer Paid Amount**
Total	**$150.00**		**$50.00**	**$40.00**

Contractors send the following other payer amounts to MSPPAY based on the instructions cited above.

OTAF:	**$50.00 (lowest OTAF)**
Other Payer Paid Amount:	**$110.00 (combined total other payer paid amounts)**

E –

60 - **MSP** Reports

(Rev. 1, 10-01-03)

A3-3899, B3-13450

60.1 - Monthly Intermediary Report (Form CMS-1563) and Monthly Carrier Report (Form CMS-1564) on Medicare Secondary Payer Savings

(Rev. 1, 10-01-03)

A3-3899.1, B3-13450.1

Each month contractors must electronically transmit to CMS Central Office a Monthly Intermediary Report (Form CMS-1563) and a Monthly Carrier Report (Form CMS-1564) on Medicare Secondary Payer Savings via the IBM PC. Contractors continue to use existing dial-up instructions and the RLINK software sent to contractors. (See §60.1.3.3.) Hard-copy reports are not required. Contractors transmit a separate report for each office assigned a separate contractor number and also, for each State for which the contractor has been designated the servicing contractor for one or more providers. Contractors are not required to complete an individual State report for those States in which there is no MSP activity during the month (reports that would show zeros in every category, including pending).

60.1.1 - Overview of Report

(Rev. 1, 10-01-03)

A3-3899.2, A3-3899.3, A3-3899.4, B3-13450.2, B3-13450.3, B3-13450.4

A - Purpose and Scope

The Monthly Intermediary Report and Monthly Carrier Report on Medicare Secondary Payer Savings supplies CMS with current data on MSP savings and MSP pending workloads.

B - Due Date

Form CMS-1563 or Form CMS-1564 is due in CO as soon as possible after the end of the month being reported, but not later than the15th of the following month. Nonreceipt of the report by the 15th will result in a telephone contact to the contractor to obtain required information.

C - Form Heading

Each contractor enters its name, assigned number, and the State in which the provider is located. In the space labeled "Reporting Period", it enters the numeric designation for month and year for which the report is being prepared, e.g., it shows “01/01” for January 2001.

60.1.2 - Savings Calculations

(Rev. 1, 10-01-03)

A3-3899.5, B3-13450.5, A3-3418.25

Savings on the Forms CMS-1563 and CMS-1564 can be recorded only for the actual amount of savings realized, plus Medicare's share of the procurement costs. Under no circumstances can more savings be claimed than actually paid in benefits. Each contractor may claim the savings for the benefits it paid out. Lead contractors may not claim savings for benefits paid by other contractors involved in the case.

A - Savings Priority

The savings priority is the order in which contractors who paid benefits in a Medicare liability settlement case may record savings at the final settlement of that case. The contractor with the first priority is the one who paid the largest amount of exhaustible benefits. Other contractors who paid exhaustible benefits are then next in line, in descending order of the amount of benefits paid. Finally, in descending order of benefits paid are those contractors that provided nonexhaustible benefits.

B - Reporting Dollar Values

The FI and carrier rounds all values to the nearest whole dollar. This includes all amounts shown on lines 2, 4, 6, 8, and 10.

C - Checking Reports

Before mailing the reports, the FI and carrier check the completeness and arithmetical accuracy as follows:

- Lines 1 + 3 + 5 = line 7 for all columns (these lines may not currently add correctly; problem is currently under review);

- Lines 2 + 4 + 6 = line 8 for all columns (these lines may not currently add correctly; problem is currently under review);

- Line 10 should be equal to, or greater than, line 9 for all columns, unless line 9 is equal to "0" in any column; in that case, line 10 should also be equal to "0" for the same column;

- For each line of the report column "i" (TOTAL), must equal the sum of the items in columns "ii" + "iii" + "iv" + "v" + "vi."

60.1.3 - Recording Savings

(Rev. 1, 10-01-03)

A3-3899.6, B3-13450.6

The FI or carrier controls all claims from which MSP savings are extracted and verifies all amounts recorded on the Forms CMS-1563 or CMS-1564 when requested.

A - MSP Savings File

The FI or carrier retains specific key identifying information on each claim counted as savings on the Forms CMS-1563 or CMS-1564. At a minimum, it records the beneficiary's name, HICN, type and dates of service, claim control number, billed charges and savings amounts reported.

B - Savings Data From Non-Medicare Sources

If savings are recorded from data obtained from the contractor's "corporate side" records or any other "outside" source, the FI or carrier extracts the same claims specific information noted above, i.e., verifies that Medicare covered services are involved and that it is able to calculate "what Medicare would have paid." In addition, contractors must compare this data with the data contained in the MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, the FI or carrier counts them as savings on the Forms CMS-1563 or CMS-1564 and enters them into the contractor MSP savings file.

60.1.3.1 - Source of Savings

(Rev. 1, 10-01-03)

A3-3899.7, B3-13450.7

The FI or carrier reports data by total and by source as shown below:

A - Column (i) - Total

All MSP savings regardless of source.

B - Column (ii) - Workers' Compensation, Black Lung, and VA

The FI or carrier includes data related to all MSP savings resulting from medical benefits provided by the WC Plans of the 50 States, the District of Columbia, Guam and Puerto Rico. In addition, it includes Federal WC provided under the Federal Employee's Compensation Act, the U. S. Longshoremens' and Harborworkers' Compensation Act and its extensions, the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal BL Program), and any fee-for-service medical care paid for by the VA. It keeps separate records for each distinct category (WC, BL, or VA).

C - Column (iii) - Working Aged

The FI or carrier includes data related to all MSP savings resulting from benefits payable under a GHP for beneficiaries aged 65 and older who are covered by reason of their own employment or the employment of a spouse of any age.

D - Column (iv) ESRD

The FI or carrier includes data related to all MSP savings resulting from benefits payable under a GHP for individuals who are entitled to Medicare benefits on the basis of ESRD during a period of up to 30 months. The period during which Medicare pays secondary benefits is defined in Chapter 2, §20.2.

E - Column (v) - Auto Medical, No-Fault and Liability Insurance

The FI or carrier includes data related to all MSP savings resulting from:

- Automobile Medical or No-Fault Insurance - Insurance coverage (including a self-insured plan) that pays for all, or part, of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

- Liability Insurance - Insurance (including a self-insured plan) that provides payment based on legal liability for injury, illness, or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It does not include situations where a beneficiary receives medical payment under his or her own homeowners' insurance.

F - Column (vi) - Disabled

The FI or carrier includes data related to all MSP savings resulting from situations where Medicare is the secondary payer for disabled beneficiaries under age 65 (except ESRD beneficiaries) who elect to be covered by a large group health plan (LGHP) based on their current employment or a family member's current employment. An LGHP is any

health plan that covers employees of at least one employer who normally employs 100 or more employees.

60.1.3.2 - Type of Savings

(Rev. 1, 10-01-03)

A3-3899.8, B3-13450.8

The FI or carrier includes data by type of savings as shown below.

60.1.3.2.1 - Unpaid (Cost Avoided) MSP Claims

(Rev. 1, 10-01-03)

A3-3899.8.A, B3-13450.8

Unpaid (cost avoided) claims are those that the contractor has returned without payment because there is strong evidence that another insurer is the primary payer and there is no indication that payment has been requested from that payer. The information indicating MSP involvement may be contained in FI or carrier files, on the CWF Auxiliary file, or on the claim itself. In addition, any information obtained from a non-Medicare source and used as the basis for claiming cost avoidance savings must meet the criteria in §60.1.3.B.

Information considered adequate for claiming cost avoidance savings includes statements on the claim noting "automobile accident," "collision," or the name of the automobile insurer. Another example would be previous information obtained that shows that GHP coverage exits. The FI or carrier does not count claims it develops as "possible" MSP situations based on routine edits as cost avoidance savings unless there is previous information that another payer has primary responsibility. For example, "trauma code" edits are not, by themselves, considered strong evidence that Medicare is the secondary payer.

Line	Name	Instruction
Line 1	Number	The total number of cost avoided claims from which savings is recorded on the report.
Line 2	Dollar Value	The total dollar value of the potential Medicare payments calculated for the claims on Line 1 that will be saved if the primary payer makes a payment that relieves Medicare of all payment liability.

The amount of cost avoided is **what Medicare would have paid**. **The FI or carrier** must not count total charges as cost avoided savings.

For intermediaries the cost avoided amount is the "Medicare payment rate" or the "current Medicare interim reimbursement amount" less any coinsurance amount applicable. It reduces Part B services subject to coinsurance for the coinsurance amount or uses a "coinsurance reduction factor" of 19 percent to calculate coinsurance charges for all Part B services. It may assume that the deductible has been met.

Carriers reduce the cost avoided amount based upon reasonable charge and coinsurance calculations:

- **Reasonable Charge Reductions -** The reasonable charge amount may be calculated through the actual reasonable charge methodology or through a "reasonable charge reduction factor" which is the percentage derived from the most current Forms CMS-1565A by dividing line 3 (Total Amount of reduction) by Line 1 (Total Covered Charges for All Claims). (See the Medicare Financial Management Manual, Chapter 6, §240.2.)

- **Coinsurance -** The carrier reduces line items subject to the Part B coinsurance by that amount or applies a "coinsurance reduction factor" of 19 percent to all charges.

A - Cost Avoidance Savings

Cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. To prevent duplicate counting, the FI or carrier suspends all claims returned unpaid. It sets up a control on the claim when it is returned for development. It maintains this control for 75 days, unless further information is received before that time which allows processing the claim. If no further information on the claim is received, the claim may be denied after 75 days. Contractors are required to continue tracking the claim, but retain the key identifying information on the claim, as described in §60.1.3.A.

The CMS prefers cost avoidance savings only after 75 days have elapsed. However, contractors do have the option of counting the savings when the claim is initially suspended or at any time during the suspension period. If the latter alternative is selected, the FI or carrier adjusts cost avoidance savings if the claim is resubmitted during the suspension period with information showing it is not a legitimate cost avoidance.

NOTE: The carrier may not return a Nona signed claim to a beneficiaries, but must control it as described above when the claim is being developed for MSP involvement and counted as cost avoidance savings.

The following situations require special consideration if cost avoidance savings are counted before the 75 day suspense period has ended:

- A claim returned (and counted as cost avoided) is paid in part by another payer and the provider resubmits it for secondary payment.

- A claim returned (and counted as cost avoided) is denied by the other payer and the provider resubmits it for primary payment.

- A claim returned (and counted as cost avoided) is paid in full by the other payer and the provider submits a no-payment bill. The FI or carrier shows "full recovery" savings and not cost avoidance.

In these situations, the FI or carrier adjusts the cost avoidance savings figures by deducting or "backing out" the applicable amounts. It makes the adjustments in the reporting month in which a final determination is rendered. The following chart outlines the correct reporting of savings in each situation.

ADJUSTMENTS TO REPORTED MSP COST AVOIDANCE SAVINGS

CLAIMS PROCESSING ACTIONS	**MSP SAVINGS REPORTED**		
	Cost Avoidance	**Partial Recoveries**	**Full Recoveries**
I. Partial Recovery Adjustment - Intermediary			
• MSP situation indicated. Intermediary calculated the Medicare payment to be $1200 if Medicare was primary payer. Claim is returned to submitter.	$1,200		
• Provider resubmits the claim to the intermediary showing $900 paid by the other insurer. Medicare secondary payment of $300 is made.	$(1,200)*	$900	
II. Partial Recovery Adjustment - Carrier			
• MSP situation indicated. Carrier calculated the Medicare payment to be $50 if Medicare was primary payer. Claim is returned to submitter.	$50		
• Claim is resubmitted to the carrier showing $30 paid by the other insurer. Medicare secondary payment of $20 is made.	$(50)*	$30	
III. "Other Payer Denial" Adjustment - Intermediary			
• MSP situation indicated; Medicare	$2,000		

CLAIMS PROCESSING ACTIONS	MSP SAVINGS REPORTED		
	Cost Avoidance	**Partial Recoveries**	**Full Recoveries**
"primary" payment by the intermediary is, $2,000. Claim is returned to providers.			
• Other payer denies claim. Medicare found to be primary and Medicare payment of $2,000 is made.	$ (2,000) *		
IV. "Other Payer Denial" Adjustment - Carrier			
• MSP situation indicated; Medicare's "primary" payment by the carrier is calculated to be $75. Claim is returned to submitter.	$75		
• Other payer denies claim; Medicare found to be primary and Medicare payment of $75 is made.	$ (75)*		
V. Full Recovery Adjustment - Intermediary			
• MSP situation indicated - Medicare "primary" payment, $900. Claim is returned to provider.	$ 900		
• Provider submits a "no-payment" bill showing full payment by the other payer.	$ (900) *		$ 900
VI. Full Recovery Adjustment - Carrier			
• MSP situation indicated: Medicare's "primary" payment calculated to be $80. Claim is returned to submitter.	$ 80		
• Submitter or other source informs carrier that full payment was made by the other payer.	$ (80)*		$ 80

*Amounts "backed out" of cost avoidance savings figures.

60.1.3.2.2 - Full Recoveries

(Rev. 1, 10-01-03)

A3-3899.8, B3-13450

Line	Name	Instruction
Line 3	Number	Report the number of full recoveries made during the month.
Line 4	Dollar Value	Report the dollar value of full recoveries made during the month.

Full Recoveries are claims where the primary payer made a payment that relieved Medicare of all payment liability. Full recoveries can be either prepayment or postpayment. Fiscal Intermediaries and carriers count full recoveries in the month in which the full payment is recovered or for prepayment a no-payment bill is received. Where the "full recovery" is paid in installments, the FI or carrier counts the claim as pending until all monies have been received. Instructions for processing full recovery claims are in §§40.6.1 and 40.8.

Carriers count full recoveries in the month in which a final determination on the claim is rendered. In post payment situations, this is when the carrier has recovered the full amount paid by Medicare. In prepayment situations it is when the carrier received documentation showing that an MSP resource made a payment equal to or greater than what Medicare would have paid.

A - Prepayment Full Recovery

A prepayment full recovery occurs when a primary payer makes full payment on a charge before Medicare makes any payment.

Intermediary Example

A hospital identifies a GHP as the primary payer, submits its charge to that insurer, and the GHP pays the hospital's full cost. The intermediary subsequently receives a "no pay" bill. It determines what Medicare would have paid if the GHP had not made payment and records that total as a full recovery savings.

Carrier Example

A physician identifies a GHP as the primary payer, submits the bill to that insurer, and the GHP pays the charges in full. The beneficiary informs the carrier of this and submits a copy of the GHP explanation of benefits. The carrier determines what would have been paid if the GHP had not made payment and records that total as full recovery savings.

B - Postpayment Full Recovery

A postpayment full recovery occurs when a primary payer makes full payment on a charge after Medicare has paid.

Contractor Example

Medicare paid a hospital bill for charges incurred as a result of an automobile accident. Subsequently, an auto liability insurer reimburses the Medicare beneficiary for the full amount of the medical expenses and the beneficiary refunds that amount to Medicare. The contractor counts the amount of Medicare's initial payment as a postpayment full recovery.

It records as savings, that portion of a full recovery paid to an attorney or other agent as Medicare's share of the recovery cost. Consequently, there may be instances where Medicare has made a full recovery but did not get back the full amount paid. When the intermediary or carrier refers a case to the RO for recovery action, however, it does not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. The contractor does not count these cases for CPE credit prior to final settlement.

EXAMPLE

A beneficiary incurs a $1,000 physician's bill and a $5,000 hospital bill as a result of injuries sustained in an automobile accident. If all deductibles are satisfied, Part B pays $800 toward the physician's charges, and Part A covers the hospital bill in full. After litigation, a liability insurer agrees to pay $6,000 for the beneficiary's medical expenses from which the attorney takes a fee. (If the attorney's fee were 33 percent, the dollar recovery would be $4,000.)

The Part B contractor can record $800 in Full Recovery savings. Contractors are also allowed to count the Medicare payment as a Full Recovery savings even though the amount recovered, due to attorney's fees, does not equal what was paid.

60.1.3.2.3 - Partial Recoveries

(Rev. 1, 10-01-03)

A3-3899.8, B3-13450

Line	Name	Instruction
Line 5	Number	Report the number of partial recoveries made during the month.
Line 6	Dollar Value	Report the dollar value of partial recoveries made during the month.

Partial recoveries are those savings realized when a primary payer makes a payment which covers only a part of the Medicare allowable charge, leaving Medicare with a balance to pay.

The FI or carrier uses the following formula in computing the savings from a partial recovery:

- The dollar amount of Medicare benefits available for the services or supplies (calculated as if Medicare were the primary payer) less the Medicare benefits paid for the services or supplies, equals the partial recovery savings. (Primary Payment -Actual Payment = Partial Recovery Savings)

The FI or carrier counts partial recoveries in the month when final action is taken on the claim (either making a payment supplemental to that of the primary payer or making a partial recovery from a payment by the primary payer). Instructions for processing partial recovery claims are in the Medicare Claims Processing Manual.

The FI or carrier records as savings, that portion of a partial recovery paid to an attorney or other agent as Medicare's share of the recovery cost. When a case is referred to the RO for recovery action, however, the FI or carrier does not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. These cases may not be counted for CPE credit prior to final settlement.

60.1.3.2.4 - Totals

(Rev. 1, 10-01-03)

A3-3899.8, B3-13450

In this part of the report (lines 7 and 8), the FI or carrier reports data on the totals of unpaid claims plus full and partial recoveries.

Line	Name	Instruction
Line 7	Claims	The FI or carrier reports the total number of MSP claims handled during the month
Line 8	Dollar Value	The FI or carrier reports the total dollar value associated with MSP claims during the month.

60.1.3.2.5 - Pending Claims/Cases

(Rev. 1, 10-01-03)

A3-3899.8, B3-13450.8

Line	Name	Instruction
Line 9	Number	The FI or carrier reports the number of pending claims/cases as of the close of the reporting month. It includes claims/cases for which "Full Recovery" is expected but not all money due has been received.
Line 10	Estimated Value	The FI or carrier reports the gross charges for all claims/cases reported as pending on line 9. Where "Full Recovery or Partial Recovery" has been determined, but not all monies have been received, it reports the gross charges until it receives the full amount due or it is reasonable not to expect further payments.

A case is defined as one or more claims filed on behalf of an individual and related to one specific occurrence that necessitated medical care. When recording data for column 1 concerning WC, Auto Liability, and No-Fault Insurance, the FI or carrier counts only cases. For Working Aged (column iii), ESRD (column iv), and Disabled (column vi), the FI or carrier counts each individual claim.

A case/claim is pending only after it has been developed to the point where it is determined to be an MSP claim and no final resolution has been made. A partial or interim payment is not sufficient to remove a case/claim from the pending inventory. Final resolution occurs when there is no longer a practical expectation of further reimbursement.

Remarks: The FI or carrier enters any comments relevant to the interpretation and analysis of the report.

Signature: The individual responsible for its compilation signs the report.

Date: The FI or carrier enters the date that the report is completed and signed.

60.1.3.2.6 – Total Post-payment Savings

(Rev.)

60.1.3.3 - Electronic Submission

(Rev. 1, 10-01-03)

A3-3899.9, B3-13450.9

60.1.3.3.1 - Data Entry of the Forms CMS-1563 and CMS-1564

(Rev. 1, 10-01-03)

A3-3899.9, B3-13450.9

The FI or carrier uses existing RLINK dial-up instructions.

- Intermediaries key letter "L" to bring up a blank Form CMS-1563, Carriers key letter "K" to bring up a blank Form CMS-1564, and;
- Enter valid 5-digit intermediary or carrier number. Use the tab key to move from column to column.
- Enter reporting period using a numeric designation for month and year, e.g., 0102 for January 2002;
- Enter a 2-position alpha State code;
- Complete each column of data. Fields with zero do not have to be keyed. The system will presume all blank fields to be zero;
- Do not key dollar signs or commas. Key only whole dollar amounts;
- After completing the form, press the F1 key. The system will edit and print any error messages on the line above "contractor number." Tab to the incorrect field and reenter the correct data. When all edits are passed, a message will appear "record has been written." Press the F4 key to return to the menu;
- To abort at any time without writing a record, press the F3 key and refer to CICS instructions.
- To verify that a report has been written, return to the main menu (F4) and intermediaries key "L" and carriers key "K" to bring up a blank form. Key in contractor number, reporting period and State code. Press the F7 key. A completed report should appear on the screen.

60.1.3.3.2 - Edits for Forms CMS-1563 and CMS-1564

(Rev. 1, 10-01-03)

A3-3899.9, B3-13450.9

The following edits are performed on the Forms CMS-1563 and CMS 1564;

- A valid 5-digit intermediary number is required on the Form CMS-1563 or;
- A valid 5-digit carrier number is required on the Form CMS-1564; and;
- The default value for areas not keyed is zero;
- Appropriate reporting period (MMYY) is required;
- Enter the 2-position alpha State code;
- Lines 1 + 3 + 5 must equal line 7 for all columns;
- Lines 2 + 4 + 6 must equal line 8 for all columns;
- Line 10 must be equal to or greater than line 9 for all columns unless line 9 is zero. In that case line 10 must also be zero;
- For each line of the report column i must equal the sum of columns ii + iii + iv + v + vi.

60.2 - Liability Settlement Tracking Report

(Rev. 1, 10-01-03)

A3-3418.26

See Chapter 7, §50.9.

70 - Hospital **Review** Protocol for Medicare Secondary Payer

(Rev. 1, 10-01-03)

A3-3693, HO-480

Federal law mandates that Medicare is the secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who are insured by GHP coverage based upon their own current employment with an employer that has 20 or more employees, or that of their spouse's of any age, or the beneficiary is covered by a multiple employer, or multi-employer, group health plan by virtue of

their, or a spouses, current employment status and the GHP covers at least one employer with 20 or more employees;

Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage that was already secondary to Medicare at the time ESRD occurred (see Chapter 2, §10.2);

- Claims involving automobile or non-automobile liability or no-fault insurance (see §20.2);
- Claims involving government programs, e.g., WC, services approved and paid for by the Department of Veterans Affairs (DVA), or BL benefits; and
- Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon their own current employment status or the current employment status of a family member.

The following sections provide a methodology for reviewing hospitals' MSP policies and practices to ensure that hospital procedures comply with the law. The FI or carrier shall review hospital admission and bill processing procedures.

70.1 - Reviewing Hospital Files

(Rev. 1, 10-01-03)

A3-3693.1, HO-480.1, HO-480.2, HO-480.4

In order to conduct an effective review, the FI or carrier obtains complete files from the hospital on all beneficiaries represented in the bills selected for review. (See §70.2 concerning sample selections.) For the purposes of this review, a complete file must contain:

- A copy of the completed UB-92 (Form CMS-1450) or its facsimile;
- A copy of the admission questionnaire (the beneficiary's signature on the questionnaire is not required; see §70.3.B). If the hospital uses an online query process, no hardcopy form need appear in the file. Screen prints may be used instead (see §70.1.2.B); and
- Beneficiary's MSN form for all secondary claims.

70.1.1 - Frequency of Reviews and Hospital Selection Criteria

(Rev. 1, 10-01-03)

A3-3693.2, HO-480.3, HO-480.6

Each year the intermediary shall conduct a review of 10 percent of the hospitals for which it has Medicare claims processing responsibility. Considering the variations within each State as to number of hospitals that would be reviewed, it shall review a minimum of four and a maximum of 20 hospitals, using the 10 percent criterion as a bench mark for determining the actual number. Hospitals to consider for review include those which:

- Fail to develop MSP claims properly;
- Fail to submit "no payment" bills; and
- Do not submit auto accident cases (even if they have shock trauma units specializing in emergency admissions).

The intermediary shall refrain from repeatedly selecting the same hospital for review each year. A hospital reviewed within the last 12 months is not to be reviewed the following year if there are hospitals that were not reviewed during the preceding 12 months, unless serious deficiencies are identified. The objective of hospital reviews is to review all hospitals in the contractor's geographic area. The review period generally lasts a maximum of two days.

70.1.2 - Methodology for Review of Admission and Bill Processing Procedures

(Rev. 1, 10-01-03)

A3-3693.3, HO-480.5

A - Entrance Interview

The intermediary shall conduct an entrance interview with the admissions staff (including inpatient, outpatient, and emergency) to determine whether the hospital established:

1. Policies identifying other payers; and
2. A system in which such policies are carried out in practice.

It shall use the checklist found in §70.5.3, Exhibit 3 to conduct the entrance interview. During the interview, it shall request a descriptive walk-through of the admissions process. It is not necessary to observe an actual admission of a beneficiary.

B - Review of Hospital Admission Questionnaire

The intermediary shall review copies of the hospital's inpatient, outpatient, and emergency room (ER) hospital admission questionnaires. If the hospital uses an online admission query process, it shall review the system screen prints. If the hospital has both hard copy questionnaires and online questionnaire responses, the reviewer may exercise discretion in deciding whether to review hard copy questionnaires or online responses (or both, if desired). The reviewer shall compare the hospital's admissions questionnaire to the model found in the Medicare Claims Processing Manual, Chapter 2, Admission and Registration § **20.1.2**) to ensure that it includes all mandatory questions. If the form contains the mandatory questions and additional information not required by CMS, the reviewer shall disregard the additional information for purposes of the review.

Analysis of the admission questionnaire for purposes of insuring that it matches the information billed should be undertaken during the review of billing procedures. (See §70.3.B for instructions.)

70.2 - Selection of Bill Sample

(Rev. 11, 02-27-04)

A3-3693.4, HO-480.7

The sample period shall be determined by selecting the sample from one month of the hospital's bill submissions. The intermediary shall notify the hospital in advance of the month's claims to be reviewed. For example, if the review examines December bills, the intermediary shall notify the hospital no later than November 30 to permit the hospital time to segregate Medicare patient bills in advance. The reviewer is not required to perform the review during the same month as the month of bills selected. The reviewer shall make an effort to conduct the review within three months after the sample period. The hospital shall provide the reviewer with one month's bills from which to select the bill sample.

The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. The reviewer shall select the sample using the following criteria:

- At least 2/3 of the sample should consist of inpatient bills. The remaining 1/3 is to be outpatient bills. The split is to be determined at the reviewer's discretion;
- The sample must contain a minimum of 20 bills and a maximum of 60 bills;
- The reviewer shall include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed;
- The sample is to include a mixture of bill types from the hospital's bill universe. Accordingly, if the hospital does not submit ESRD bills, then the reviewer is not required to review that particular bill type; and

- Both Medicare primary and secondary bills are to be included in the sample.

- *Claims for reference laboratory services, as described in section 943, subsection (b), listed below, of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, shall not be included in the sample of claims that are audited during MSP hospital reviews. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.*

(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

70.3 - Methodology for Review of Hospital Billing Data

(Rev. 1, 10-01-03)

A3-3693.5, HO-480.8

A - Entrance Interview

The reviewer shall conduct an entrance interview with the billing staff to determine whether the hospital established:

1. Policies concerning billing other payers; and

2. A system in which such policies are carried out in practice.

Both these areas are to be examined in one interview. The reviewer shall use the checklist found in §70.5.4, Exhibit 4 to conduct the entrance interview. During the interview, the reviewer shall request a walk-through of the billing process.

B - Comparing Completed Admission Questionnaire With Bills

The reviewer shall request completed inpatient, outpatient, and ER admission questionnaires (or screen prints for hospitals using online admission query systems) for each Medicare beneficiary included in the bill sample. (See §70.2 concerning selection of sample.) It is not necessary that the beneficiary sign the completed questionnaire.

The form may be kept as paper, optical image, microfilm, or microfiche. If the hospital uses online admission screens, it is not necessary to obtain a copy of an admission form or screen print as long as the hospital has documented procedures for collecting and reporting other primary payer information. The reviewer may request screen prints, if necessary. Hospitals with online query systems are encouraged to retain affirmative and negative responses to the questionnaire for 10 years after the date of service. Should a hospital choose not to retain this information for up to 10 years, it does so at its own risk.

The reviewer shall analyze the admission questionnaire, or online admission query procedures, for Medicare beneficiaries to determine whether the information provided on

the questionnaire matches the bill. The reviewer shall check to see whether each response to the questionnaire is reflected on the bill. For example, the reviewer shall check to ensure that the primary payer reflected on the questionnaire is shown as primary on the bill, name and address of insurer(s) on questionnaire matches that on the bill, etc. Reviewers should check this admissions information at the same time the bill review is conducted.

70.3.1 - Review of Form CMS-1450

(Rev. 1, 10-01-03)

A3-3693.5.C, HO-480.5.C

The reviewer shall obtain all Form CMS-1450s, also known as the UB-92, for each case included in the sample. The reviewer shall separate the bills according to bill type. The reviewer shall determine the amount billed to Medicare for each case. The reviewer shall review Form CMS-1450 for the following MSP data to determine if the billed amount is accurate and to conduct the comparison process using the admissions questionnaire described at §70.5.3, Exhibit 3. Item numbers reflect Form CMS-1450 field locators. (See the Medicare Claims Processing Manual, Chapter 25, for a complete definition of these items.)

70.3.1.1 - General Review Requirements

(Rev. 1, 10-01-03)

A3-3693.5.C.1

The reviewer shall review the following items, which are not specific to a particular bill type.

A - Condition Codes: FLs 24 thru 30

The following condition codes must be completed where applicable:

- 08 - Beneficiary would not provide information concerning other insurance coverage;
- 09 - Neither patient nor spouse employed;
- 10 - Patient and/or spouse is employed, but no GHP; or,
- 28 - Patient and/or spouse's GHP is secondary to Medicare.

B - Occurrence Codes and Dates: FLs 32 thru 36

The following occurrence codes must be completed where applicable:

- 18 - Date of retirement (patient/beneficiary);
- 19 - Date of retirement (spouse);
- 24 - Date insurance denied; or,
- 25 - Date benefits terminated by primary payer (date on which coverage, including Workers' Compensation benefits or no-fault coverage, is no longer available to patient)

In relation to the reporting of occurrence codes 18 and 19, referenced above, hospitals are now instructed that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:

When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, report his or her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his or her retirement date.

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it has been at least five years since the beneficiary retired, enter the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997. As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

C - Value Codes and Amounts: FLs 39 thru 41

Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services. Where the hospital is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

D - Payer Identification: FL 50A

Payer identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A.

E - Payer Identification: FLs 50B, C

Payer identification should be completed to show when Medicare is the secondary or tertiary payer.

F - Insured's Name: FL 58A

The insured's name should be completed to show the name of the individual in whose name the insurance is carried. This information is of particular importance when Medicare is not the primary payer.

G - Patient's Name: FL 58B

In FL 58B, the hospital should have entered the patient's name as shown on the HI card or other Medicare notice or as annotated in the hospital's system.

H - Patient's Relationship to the Insured: FL 59

This item indicates whether the individual may have coverage based on the current employment status of a spouse or other family member.

I - Certification/SSN/HICN: FLs 60A, B, C

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the hospital should have entered the patient's Medicare HICN. If the hospital is reporting any other insurance coverage higher in priority than Medicare (e.g., employer coverage for the patient or the spouse or during the first 30 months of ESRD entitlement), the involved claim number for that coverage should be shown on the appropriate line.

70.3.1.2 - Working Aged Bills

(Rev. 1, 10-01-03)

A3-3693.5.C.2

A - Value Codes and Amounts: FLs 39 thru 41

The following value code and amount fields should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

- 12 - Working aged/beneficiary/spouse with group health plan coverage

70.3.1.3 - Accident Bills

(Rev. 1, 10-01-03)

A3-3693.5.C.3

A - Occurrence Codes and Dates: FLs 39 thru 34

The following occurrence codes should be completed to show the type and date of the accident:

- 01 - Auto accident;
- 02 - Auto accident with no-fault insurance;
- 03 - Accident involving civil court process;
- 04 - Employment related accident;
- 05 - Other accident

B - Value Codes and Amounts: FLs 39 thru 41

The following value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services:

- 14 - Automobile, or other no-fault insurance;
- 47 - Any liability insurance;

When occurrence codes 01 thru 04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in FLs 39-41 (shown here) if there is another payer involved.

70.3.1.4 - Workers' Compensation Bills

(Rev. 1, 10-01-03)

A3-3693.5.C.4

A - Condition Codes: FLs 24 thru 30

Condition codes should be completed with condition code 02 if the condition is employment related.

B - Value Codes and Amounts: FLs 39 thru 41

The following value code and amount should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

- 15 - Workers' compensation

70.3.1.5 - ESRD Bills

(Rev. 1, 10-01-03)

A3-3693.5.C.5

A - Value Codes and Amounts: FLs 39 thru 41

The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

- 13 - ESRD beneficiary in 30-month period with group health plan coverage

70.3.1.6 - Bills for Federal Government Programs

(Rev. 1, 10-01-03)

A3-3693.5.C.6

A - Value Codes and Amounts: FLs 39 thru 41

The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services:

- 16 - PHS, other Federal agency; and,
- 41 - Black lung.

70.3.1.7 - Disability Bills

(Rev. 1, 10-01-03)

A3-3693.5.C.7

A - Value Codes and Amounts: FLs 39 thru 41

The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

- 43 - Disabled beneficiary with large group health plan coverage

70.3.2 - Use of Systems Files for Review

(Rev. 1, 10-01-03)

A3-3693.5.D

The reviewer shall use intermediary paid history files, MSP control files, and any other relevant data to assist in evaluating hospital procedures used in processing claims included in the sample. The purpose of a review is to determine whether the hospital has filed any improper claims. This can be accomplished by reviewing certain files before the on-site review, and other files after the review, subject to the reviewer judgment concerning the most effective use of a particular file.

The following areas should be reviewed against the intermediary internal files:

- Claims denied to determine whether a hospital is using information from an admission questionnaire properly;
- Claims paid to determine if proper amounts are being billed;
- No-pay bills. The reviewer shall check the intermediary files to determine if the hospital is submitting no-pay bills;
- Adjustments to determine whether an automatic adjustment was needed. The reviewer may exercise discretion in determining what documentation is needed to justify the adjustment made; and
- IRS/SSA/CMS data match denials to determine whether a claim reflects changes in the beneficiary's current employment status.

In cases where the reviewer ascertains that an improper claim has been filed, the reviewer shall document these instances on the assessment form. (See §70.5.1, Exhibit 1.)

70.3.3 - Review of Hospitals With Online Admissions Query

(Rev. 1, 10-01-03)

A3-3693.6, HO-480.6

While hospitals that solicit admission data through an online process are not required to retain hard copies of admission questionnaires, they must utilize a specific set of admission questions that seek the appropriate MSP information. The hospital must demonstrate that responses to admission questions asked are retained, and match the information shown on the bill. The reviewer shall use the same review requirements described in §70.3. Although not required, the use of screen prints of admission questions will likely facilitate easier review, particularly for the bill comparison process described at §70.2. The reviewer shall notify the hospital in advance of any screen prints that are needed.

70.4 - Assessment of Hospital Review

(Rev. 1, 10-01-03)

A3-3693.7, HO-480.7

The reviewer shall complete the assessment form (§70.5.1, Exhibit 1) for each hospital reviewed. The reviewer shall include selection criteria for the hospital, findings, and suggested recommendations, if appropriate. The reviewer shall include any discrepancies between the hospital's MSP policies and practices, as well as any hospital innovations that have been/are being devised to determine third party payer resources. The reviewer shall note any discrepancies between the hospital's MSP policies and those required by law. The reviewer shall complete the Survey of Bills Reviewed, provided as an attachment to the assessment form. (See §70.5, Exhibit 2.) The reviewer shall indicate whether any follow-up action is needed in the appropriate column. If no follow-up action is needed, the reviewer shall enter "none." If action is needed, the reviewer shall briefly describe action required and time frame within which follow-up will commence. It is not necessary to estimate when action will be completed. The intermediary shall send a copy of the assessment form, with its attachment, to the MSP Coordinator in the RO within 30 days of the date the review is completed.

It shall send the hospital a copy of the assessment form as well. It shall follow-up every 30 days until appropriate corrective action is taken. It shall report continued problems after three months to the RO MSP Coordinator.

70.5 - Exhibits

(Rev. 1, 10-01-03)

A3-3693.8

Exhibit 1 - Assessment of Medicare Secondary Payer Hospital Review

Exhibit 2 - Survey of Bills Reviewed

Exhibit 3 - Entrance Interview Checklist: Admissions Questionnaire and Procedures

Exhibit 4 - Entrance Interview Checklist: Billing Procedures

70.5.1 - Exhibit 1: Assessment of Medicare Secondary Payer Hospital Review

(Rev. 1, 10-01-03)

Intermediary Name and No.: _____

ASSESSMENT OF MEDICARE SECONDARY PAYER HOSPITAL REVIEW

1 Name of hospital reviewed

2 Number of cases reviewed

3 Period of review (month/year)

4 Selection criteria used to determine why hospital selected for review. (See §70.1.1)

5 Describe findings in accordance with review protocol standards found at §70.3 and §70.4.

6 Recommendations

cc: CMS Regional Office, MSP Coordinator

Hospital Reviewed

Attachment: Survey of bills reviewed.

70.5.2 - Exhibit 2: Survey of Bills Reviewed

(Rev. 1, 10-01-03)

Name of Beneficiary	HICN	Bill Type	Follow-Up Action Needed (Action Date)

70.5.3 - Exhibit 3: Entrance Interview Checklist

(Rev. 1, 10-01-03)

Admissions Questionnaire and Procedures

A - Admissions Procedures

1 When is other payer information solicited? (During billing or during admission?)

2 Describe the process followed to solicit MSP information.

3 Do admissions staff receive training on soliciting MSP information? If so, describe the training. Do you think the staff understands the admissions questions well enough to solicit information and/or explain to beneficiaries?

4 Is MSP information obtained primarily from the patient, Medicare Common Working File, or in some other way?

B - Questionnaire

1 Are the admissions questionnaire data solicited through an online query (i.e. are the admissions questions asked and responses retained online)?

2 Do you re-administer the questionnaire each time the patient is admitted? (It should be administered once per admission.)

3 Do you require the beneficiary's signature on the questionnaire? (No signature is required, and the hospital should be informed, if necessary.)

4 Are there written hospital policies, instructions or procedures concerning soliciting third party payer information? (Request copies for review.)

5 How long are admission questionnaires retained, either online, in files, or both? (Requirements are found at §70.3.)

70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures

(Rev. 1, 10-01-03)

1 Does the hospital bill for all bill types?

2 Are all claims electronically billed?

3 Is the information pertaining to a payer primary to Medicare contained on the admission questionnaire, or in an online database, available in its entirety to the billing department? (The billing department must be made aware of a payer primary to Medicare, e.g., working aged, ESRD, liability insurance.)

4 Do circumstances arise where the billing department obtains information directly from the patient? How is it obtained? Is the regular admissions form used to obtain the information in these situations?

5 Where there is the possibility of payment by a Federal government grant program, how does the hospital bill Medicare? (Determine whether the hospital bills both the grant program and Medicare, or only Medicare.)

6 How does the hospital bill the Department of Labor where the services are covered by the Federal Black Lung (BL) program? (The hospital should bill the black lung program first.)

7 Does the hospital have the ability to track workers' compensation (WC) cases on succeeding visits to the hospital or the outpatient department? Describe the tracking mechanism. How does the hospital bill for the succeeding visits? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.)

8 Does the hospital bill more than one primary insurer simultaneously? (Providers are prohibited from billing more than one insurer for primary payment. Reviewer should request a credit balance report for this aspect of the review.)

9 Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay for the services, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

10 What is the hospital's policy on submission of no-pay bills?

11 Where a GHP or LGHP is the primary payer because the beneficiary is either working aged or disabled, or is involved in a no-fault or liability case, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

Attachment 1 - Electronic Correspondence Referral System (ECRS) User Guide v7.0 – Revised 3/2004

(Rev. 13, 03-19-04)

View Attachment 1, Electronic Correspondence Referral System (ECRS) User Guide, *Software Version 7.0, User Guide Version v7.1 – Revised 3/2004*

Below are the enhancements and fixes that have been applied to ECRS User Guide *v*7.0 *and v7.1.*

ENHANCEMENTS:

The following enhancements are included as part of version 7.0 *and User Guide v7.1.* For more information regarding ECRS 7.0 enhancements, refer to *CR3026.*

1) Change of Venue limited to Workers' Compensation Cases

Authorized users may only request a change of venue for *Workers' Compensation* cases. The online edit message "Action code 'CV' is invalid for MSP Types D or L" will display if a user attempts to request a change of venue for MSP types D and L.

2) ECRS Code Selection Screen

The ECRS Code Selection Screen has been enhanced to provide look-up capability for MSP type, patient relationship, and class action codes. Additionally, when a user is transported to the ECRS Code Selection Screen, a sub-heading will display indicating the name of the codes being looked up.

3) Enhancement to the HIMR MSPA Screen

The following message will display on the HIMR MSP Data Screen: "Type G in the select field to retrieve the desired record."

4) Development Source and Response codes

CWF Assistance Requests - The CWF Assistance Request will display a development source code to indicate where development was sent. Development values for CWF Assistance Requests are:

A - Attorney
B – Beneficiary
C – Contractor
E – Employer
R – Beneficiary Representative
I – Insurer
P – Provider (other than attorney)

If a response was received from the development, a 'Y' will display in the response field.

MSP Inquiries – The MSP Inquiry will display up to two development source codes to indicate where the development was sent. Development values for MSP *Inquiries* are:

A - Attorney
B - Beneficiary
E - Employer
I - Insurer
P - Provider
R - Beneficiary Representative (other than attorney)

If a response was received from the development, one of the above values will display in the response field indicating who the response was received from.

5) New Action Codes For CWF Assistance Requests

The following action codes will be valid for CWF Assistance Requests:

AR - Add CWF Remark Codes
CT - Change the termination date
DA - Develop to the attorney
DD - Develop for the diagnosis code
DT - Develop for the termination date
EF - Develop for the effective date

Note: There is no automatic processing for these action codes.

6) New Reason Code for MSP Inquiries

Reason code *91* (duplicate in process) will display with a completed status. In this situation, an MSP Inquiry has already been submitted, but not completed.

7) New Class Action Type

Contractors may now add '07' (Baycol litigation) as a valid class action type. Beneficiary State logic will be used to assign the lead contractor.

8) 'Send to CWF' Switch on MSP Inquiries

The 'Send to CWF' switch will now display on page 1 and page 2 of an MSP Inquiry.

9) New State Codes

The following are now valid state codes:

AS - American Samoa
FM - Federated States of Micronesia
MH - Marshall Islands
MP - Northern Mariana Islands
PW - Palau

10) Processing Changes to the Workers' Compensation Set-Aside Detail Screens

A new Workers' Compensation Set-Aside Case Control System (WCCCS) will go into production for use by the RO's and the COBC in FY2004. All new Set-Aside cases will be entered through the new WCCCS. Set-Aside cases in ECRS entered before the May 3, 2004 production date (subject to change) will be completed through ECRS. Any set-aside case in an 'on hold' or an 'in process' status may be accessed by the RO's through the Workers' Compensation Set-Aside List Screen (option 10 on the ECRS main menu), by keying an 'S' in the selection field as is currently done today. Regional Offices may still update cases in a 'on hold' status. Since no new cases may be entered through ECRS, option 9 (Workers' Compensation Set-Aside Detail Screen) will no longer display.

11) New *Workers' Compensation* Set-Aside Inquiry Screens

New *Workers'* Compensation Set-Aside (WCSA) Cases are added through the *Workers'* Compensation Case Control System (WCCCS) located at the COB contractor and the CMS Regional offices.

The WCCCS updates ECRS when:

- A regular *Workers'* Compensation case has been added at CWF and the lead contractor assigned
- The disposition of the set-aside has been determined

The purpose of the ECRS WCSA Inquiry screens is to provide notification of the case to the lead contractor. The WCSA Inquiry screens may only be addressed through the ECRS Lead Contractor Notification Screen and are inquiry only.

12) New Patient Relationship Code

After April 2004, Contractors shall use patient relationship code "20" for Domestic Partner.

FIXES

The following items *are* fixe*s in ECRS User Guide 7.0 and 7.1* release*s*:

1) Replicate feature for CM87 - Currently if a user types an 'R' in the selection field on an inquiry that has a reason code other then 87, the system displays the inquiry as though an 'S' was typed to display the detail. We will add an online error message indicating that a 'R' is invalid for anything other then CM87.

2) CWF Indicator improperly being set to 'N' - This is happening on Non-EGHP MSP types when both insurer and attorney name and address are not present on the inquiry. The system should require one or the other, not both.

3) Remove edit for space in the second position of the Employer field – Only the insurer name should be edited for a space in the second position.

4) **Correction of a Screen Scraping** problem retrieving the incorrect record when there are more then 14 occurrences at CWF.

5) ***Deletion Reason Code*** *- All references to CM 89 should be deleted, since this is no longer applicable in ECRS.*

6) ***Correction of New Reason Code for MSP Inquiries*** *- Reason Code 90 has been changed to Reason Code 91 with the same definition (duplicate in process).*

Attachment 2 - Electronic Correspondence Referral System (ECRS) - Quick Reference Card *Revised*

(Rev. 13, 03-19-04)

View Attachment 2, Electronic Correspondence Referral System (ECRS) User Guide Quick Reference Card *Revised.*

The ECRS Quick Reference Card should be printed on 8 ½" x 14" paper. To print the ECRS Quick Reference Card:

1. When printing the ECRS Quick Reference Card, print only the first page, then manually feed the paper back into the printer to print the second page.

To fold the ECRS Quick Reference in a Z-fold:

2. With the title page side up, bring the right edge of the sheet up to meet the dotted line on the left and fold it.

3. Turn the page over clockwise. Bring the right side of the sheet up to meet the crease just made and fold it.