Program Memorandum Carriers

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

Transmittal B-02-025 **Date: APRIL 16, 2002**

CHANGE REQUEST 2007

SUBJECT: Reporting the Obligated to Accept as Payment in Full (OTAF) Amount on the ANSI X12N 837 Version 4010 as Adopted Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for Medicare Secondary Payer (MSP) Claims.

The purpose of this Program Memorandum (PM) is to provide billing instructions for physicians, suppliers and vendors on coding the OTAF amount on the ANSI X12N 4010 837. You must include all information found in the Instructions to the Industry section of this PM in your next regularly scheduled bulletin and on your web site. If you are scheduling physician, supplier and vendor training, a discussion of these instructions should be included in your training session. Only VMS, VIPs DMERC and MCS system users must implement this instruction.

Identifying the OTAF Amount

The OTAF amount is a third party payment (which is less than a physician's or supplier's charge) that a physician or supplier is either obligated to accept, or voluntarily accepts, in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

Effective October 16, 2002, physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physicians and suppliers request a one-year extension to comply with the version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF amount. All physicians and suppliers must use the X12N 4010 837 Professional Implementation Guide line level contract information (CN1) segment to report the OTAF. The OTAF amount must be reported in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, the OTAF must be reported in 2300 CN102. If MSP data is received at the line level, the OTAF must be reported in 2400 CN102. Carrier translators receiving the X12N 4010 837 must map the OTAF amount to the corresponding segment in the 4010 X12N-based flat file. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment, as described above, as well as line level reporting using the line level CN1 segment. Physicians and suppliers are to furnish line level primary payer data, including the OTAF amount, when available.

The chart found in the Instructions to the Industry section identifies the segments and data elements used to report the OTAF amount and other MSP primary payer data.

Examples 1 and 2 below show a claim service level and a line service level example based on data found on the ANSI X12N 837 (version 4010) electronic claim.

Example 1: 837 (4010) Claim Level Primary Payment Data Available

MSPPAY	837 4010 Loop, Segment and Element	Values
Claim Total Submitted Charge	(2300 CLM02)	$100.00
Claim Primary Payer Paid Amount	(2320 AMT02) D qualifier	$70.00
Claim Primary Payer Allowed Amount	(2320 AMT02) B6 qualifier	$90.00
Claim OTAF Amount	(2300 CN102)	$80.00
Claim Line Submitted Charge	(1) (2400 SV102)	$60.00
Claim Line Submitted Charge	(2) (2400 SV102)	$40.00

The MSPPAY module apportions the OTAF, claim level paid amount and the allowed amount based on the ratio of submitted charges. Therefore, for line 1 MSPPAY computes a Primary Paid amount of $42.00; a primary allowed amount of $54.00 and an OTAF of $48.00. For line 2 MSPPAY computes a Primary Paid amount of $28.00; a primary allowed amount of $36.00, and an OTAF of $32.00.

Example2: 837 (4010) Line Level Primary Payment Data Available with Claim Level Totals

MSPPAY	837 4010 Loop, Segment and Element	Values
Claim Total Submitted Charge	(2300 CLM02)	$100.00
Claim Primary Payer Paid Amount	(2320 AMT02) D qualifier	$70.00
Claim Primary Payer Allowed Amount	(2320 AMT02) B6 qualifier	$90.00
Claim Line 1 OTAF Amount	(2400 CN 102)	$50.00
Claim Line 2 OTAF Amount	(2400 CN102)	$30.00
Claim Line Submitted Charge (1)	(2400 SV102)	$60.00
Claim Line Submitted Charge (2)	(2400 SV102)	$40.00
Claim Line Primary Payer Paid Amount (1)	(2430 SVD02	$40.00
Claim Line Primary Payer Paid Amount (2)	(2430 SVD02)	$30.00
Claim Line Allowed Amount (1)	(2400 AMT02)	$60.00
Claim Line Allowed Amount (2)	(2400 AMT02)	$30.00

The OTAF amount for line 1 is $50.00. The OTAF amount for line 2 is $30.00.

You may also receive line level and claim level OTAF amounts on the same claim. In that situation, if the total line level OTAF amounts equal the claim level OTAF amount, send the line level amount to MSPPAY. If the total line level amounts do not equal the claim level amount, it is the standard system's responsibility to identify this discrepancy. The claim must be returned to the physician or supplier for correction.

Instructions to the Industry

Include the following instructions to your physicians, suppliers and vendors in your next regularly scheduled bulletin and on your web site. If you are scheduling physician, supplier and/or vendor training, a discussion of these instructions should be included in your training session. You should also make reference at the end of the message below to any instruction previously released about the 837 HIPAA version 4010.

Utilizing the X12N 837 (Version 4010) When Submitting Medicare Secondary Payer (MSP) Claims

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physician and suppliers request a one year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF amount. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. On

most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When you migrate to the X12N 4010 837, you must use the line level contract information (CN1) segment to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available.

The chart below identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None
Line Primary Payer Allowed Amount	2-475-AMT02 AMT01= B6	FB0-06	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2-475-AMT02 AMT01=CT	FA0-48	2400 CN102 CN101 = 09	None

The *effective date* for this Program Memorandum (PM) is October 1, 2002.

VMS, VIPs DMERC and MCS *implementation date* for this PM is October 1, 2002.

VMS, VIPs DMERC and MCS Carrier *implementation date* for this PM is October 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 16, 2004.

If you have any questions, contact Richard Mazur at (410) 786-1418.