Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-37 **Date: AUGUST 29, 2000**

CHANGE REQUEST 1287

SUBJECT: Standard System Acceptance of Primary Payer Information at the Line Level

Accurately capturing the actual charges, the obligated to accept payment in full (OTAF) amount or what a primary payer allowed (PPA) and what a primary payer paid (PPD) for a Medicare claim is crucial in determining the appropriate amount Medicare should pay as the secondary payer. On April 1, 1998, the EDS, VIPS, and VIPS DMERC systems implemented the new version of the Medicare Part B MSPPAY module. Previous instructions released resulted in an update to the module to calculate the Medicare Secondary Payer (MSP) amount at the line level for all primary payer, explanation of benefits (EOBs). The previous version of the module could only accept aggregated information. Examples of line item processing were sent to the standard systems prior to the release of Transmittal No. 1586, Change Request 315 of the Carriers Manual Part 3.

The module was also updated to:

1. Apportion the aggregate amounts when submitted on incoming primary payer EOBs among individual service lines;

2. Accept the 95% limit on fee schedule amounts for nonparticipating physicians; and

3. Accept and calculate the 115% limiting charge for each service on unassigned claims.

VIPS, VIPS DMERC and HCFA Part B Standard System (HPBSS) (formerly UHC and currently under the EDS environment) cannot accept incoming MSP claims and primary payer EOBs at the service line level. These systems can only accept MSP claims at the claim level. MSP claims cannot be processed at the service line level; therefore, they must be aggregated and sent to the MSPPAY module for apportionment to the line level. After the claim is apportioned and MSP amounts have been calculated, the claim, and MSP payments, are then aggregated to the claim level and sent through the standard system. (Currently, EDS can accept claims at the line level, but current mapping under EDI does not allow the system to process claims to the line level fields.)

The physician or supplier charges, the OTAF amount, other payer allowed and other payer paid amounts are essential in determining the MSP payment for Medicare claims. The apportioning module, found in MSPPAY, calculates MSP payment precisely in relation to the primary payer allowed percentages of the actual physician/supplier charges are the same for all service lines. The MSPPAY module cannot take into consideration differing lines of proportionality between actual charges and third party payer (TPP) allowed charges for all line items. When the percentage among service lines is not consistent, a difference in the apportioned amounts will likely occur.

EXAMPLE: MSPPAY calculation:

Line #	Actual Charge	Service Type/ % Allowed	TPP Amt.	Medicare Pay	Apportion for MSP
1	$100	Type A; 80%	$80	Yes	$68
2	$100	Type A; 80%	Deny	Yes	$0
3	$100	Type A; 80%	$80	Deny	$68
4	$100	Type A; 80%	$80	Yes	$68
5	$200	Type B; 50%	$100	Yes	$136

Assume, for purposes of the above example, that type A are physician procedures and that type B is an evaluation and management service, such as a doctor visit.

In the above example, the total charges for the services, which will have an apportioned amount, are $500. Line 2 is not calculated since this service line was denied. The total TPP allowed charges for these services are $340. If the system assumes the same proportionality for all services, then it will apportion at the rate that results in the figures above. If all of the services had been one type (all type A or all type B), with same actual charges the apportionment by the system would yield the same number for the apportioned amount as the TPP allowed amount. Where there is a difference in the submitted charges and allowed amounts for a mixture of services, the results will yield a difference in the apportioned amounts to what the other payer actually paid.

Standard Systems Modifications and Testing

The VIPS/VMS, VIPS DMERC, and HPBSS standard systems, including the EDS/MCS system as necessary, must be updated to accept MSP claims for services at the line level. For this to occur within these standard systems, each system must be modified to:

1. Include programming to accept the incoming charges, the OTAF amount, the other payer allowed and paid amounts for incoming MSP claims at the line level;

2. Forward the service line level amounts to the MSPPAY Module for payment calculation; and

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

The MSPPAY module calculates MSP payment based on what is sent to it by the standard system. The module does not identify differences in percentages for all categories of services. The requirements to make secondary payments for items and services, rather than aggregations of same, are in the statutes; 42 CFR §411.33 is also explicit in this regard. All modifications must be tested and implemented by the affected standard systems and Medicare carriers by January 1, 2001, for the VIPS and VIPS DMERC carriers and by April 1, 2001 for HPBBS carriers.

Final recommendations and calculations will be made available by VIPS to all VIPS/VMS contractors to meet the January 2001 release date.

National Standard Format (NSF)

For DMERC and Part B standard systems, including VIPS/VMS, VIPS DMERC, HPBBS, and EDS/MCS, carriers must ensure that providers and suppliers utilizing NSF versions for the submission of MSP claims be upgraded to the NSF version that will permit the submission of MSP information at the line level and any other related fields (e.g., approved amounts). This includes information that must be mapped to the following line level fields: FA0-35.0 (primary payer paid amount); FA0-48.0 (obligated to accept amount); and FB0-06.0 (other payer allowed amount). All MSP information must be mapped to the appropriate fields. All fields as instructed by this Program Memorandum, must be made available for use to all providers and suppliers. Instructions must also be made available to providers and suppliers informing them of these changes.

MSP Claims and Medicare Summary Notices

The MSPPAY module will not be modified to exclude claim level payment processing since not all claims come in with line level information. Continue to process MSP claims at the claim level when necessary.

Within the VMS claims processing systems, if a claim is split when the PPA, PPD, and OTAF amounts are submitted at the line level, the system will correctly adjust to pay or deny without manual intervention. If a claims adjuster enters the PPA, PPD and/or OTA amounts and the total

amount for those fields at the claim level, the VMS system will validate that these amounts crosscheck. However, if a claims adjuster enters line level amounts without a corresponding claim level amount for a field, the VMS claims processing system will calculate the total claims amount. In this same vein, if the claims adjuster only enters the claim level amount, all line level amounts will remain empty.

MSP claims previously processed by the standard systems should not be automatically reopened. Reopening may be performed only under current claims reopening criteria. This is a discretionary action as defined in 42 CFR 405.841.

Claims processed, as secondary will continue to use existing Medicare Summary Notice MSP messages developed for MSP claim processing.

There are system impacts on carrier and DMERC systems for this change. No further carrier instructions will be released. This document is to be considered final instructions for the affected standard systems.

***Implementation date* for this Program Memorandum for VIPS and VIPS DMERC carriers is January 1, 2001, and HPBSS and EDS/MCS carriers April 1, 2001.**

***Effective date* for this Program Memorandum for VIPS and VIPS DMERC carriers is January 1, 2001, and HPBBS and EDS/MCS carriers April 1, 2001.**

Contact person for this Program Memorandum is Richard Mazur (410) 786-1418.

This Program Memorandum may be discarded April 1, 2002.

These instructions should be implemented within your current operating budget.