



News Flash – The Centers for Medicare & Medicaid Services (CMS) has recently updated the Educational Resources section (http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp) of the Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting web site to include the audio file and transcript from the Hospital-Acquired Conditions and Hospital Outpatient Healthcare-Associated Conditions Listening Session held on Thursday, December 18, 2008.

MLN Matters Number: MM6426 **Revised**

Related Change Request (CR) #: 6426

Related CR Release Date: June 26, 2009

Effective Date: October 1, 2009

Related CR Transmittal #: R70MSP

Implementation Date: October 5, 2009

Instructions on utilizing 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims. (This CR Rescinds and Fully Replaces CR 6275)

Note: This article was revised on June 29, 2009, to reflect the revised CR 6426, which was re-issued on June 26, 2009. The CR was revised to change the effective and implementation dates to October 1, 2009, and October 5, 2009, respectively. The CR release date, transmittal number and CR Web address were also changed. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

What You Need to Know

CR 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their use of data reported in ANSI ASC X12N 837

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

institutional CAS segments for MSP Part A Claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is Obligated to Accept as Payment in Full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements;
- Providers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 Institutional claim.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

Adjustments made by the payer are reported in the CAS segment on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as Value Code 44 in the 2300 HI Value Information. This amount is also known as the Obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the CMS Medicare Secondary Payer Manual and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional Information

You can find the official instruction (CR6426) issued to your FI, RHHI, or MAC by visiting <http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

If you have any questions, please contact your FI, RHHI, or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.