



News Flash –Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the **September 30, 2009, deadline** or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average 6-7 months to complete, the process could take as long as 9 months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at

http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp on the CMS website.

MLN Matters Number: MM6427

Related Change Request (CR) #: 6427

Related CR Release Date: March 27, 2009

Effective Date: July 1, 2009

Related CR Transmittal #: R67MSP

Implementation Date: July 6, 2009

Instructions for Utilizing 837 Professional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part B Claims (This CR rescinds and fully replaces CR6211)

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and/or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries

Provider Action Needed



STOP – Impact to You

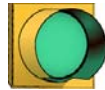
This article is based on Change Request (CR) 6427 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

Disclaimer

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**CAUTION – What You Need to Know**

CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

**GO – What You Need to Do**

Include your 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 explains why the claim's billed amount was not fully paid.

Background

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 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements,
- Physician and suppliers 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 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take

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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, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the CMS Internet Only Manuals 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Additional Information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR6427) issued to your Medicare contractor is available at <http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf> on the CMS website.

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