CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1703	**Date: MARCH 20, 2009**
	Change Request 5371

This transmittal rescinds and replaces transmittal 1665, dated January 9, 2009. The Requirements for 5371.11, 5371.12, and 5371.16.1 are updated with a technical clarification by the contractor; additionally in section 80.7, The SP 76 error was added because it was inadvertently omitted from the original chart. All other information remains the same.

Subject: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers" Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

I. SUMMARY OF CHANGES: Manual is being updated with new CWF MSP Types for WCMSAs. Background information with regard to WCMSAs has been added to the manual.

VMS will process full implementation in the July 2009 release; however, other systems will conduct analysis/design/development in the April 2009 release and coding/implementation in the July 2009 release.

New / Revised Material
Effective Date: April 1, 2009/ July 1, 2009
Implementation Date: April 6, 2009/ July 6, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	27/80.7 MSP Maintenance Transaction Error Codes

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1703	Date: March 20, 2009	Change Request: 5371

This transmittal rescinds and replaces transmittal 1665, dated January 9, 2009. The Requirements for 5371.11, 5371.12, and 5371.16.1 are updated with a technical clarification by the contractor; additionally in section 80.7, The SP 76 error was added because it was inadvertently omitted from the original chart. All other information remains the same.

SUBJECT: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers" Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

VMS will process full implementation in the July 2009 release; however, other systems will conduct analysis/design/development in the April 2009 release and coding/implementation in the July 2009 release.

Effective Date: April 1, 2009/ July 1, 2009

Implementation Date: April 6, 2009/ July 6, 2009

I. GENERAL INFORMATION

A. Background:

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates CWF in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, please visit our website at: http://www.cms.hhs.gov/WorkersCompAgencyServices.

The CMS has determined that establishing a new MSP code in the shared systems and CWF, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds.

Currently, CMS identifies situations where it has reviewed a proposed WCMSA amount on CWF by applying "WCSA" in the Group Name field of the MSP Auxiliary file. However, the application of "WCSA" on the MSP Auxiliary file does not systematically prevent CMS from making payment for claims related to the WCMSA situation. The creation of a new MSP code specifically associated with these WCMSA situation will permit automated denials of diagnosis codes associated with the open WCMSA occurrence.

B. Policy:

Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Consequently, Medicare should not make payment for future medical expenses associated with a settlement, judgment or award because payments "has been made" for such items or services. A CMS determination regarding a proposed WCMSA amount is a determination regarding the amount of future medicals associated with a particular WC settlement,

judgment or award and is to be used in making claims payment determinations once there has been a settlement, judgment or award.

The Medicare Contractors shall pay primary on claims or services that are not related to the diagnosis codes on CWF Auxiliary records with an MSP code "W", assuming that no other MSP record exists on CWF.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5371.1	The CWF and contractor shared systems shall accept a new MSP code "W" for Workers' Compensation Medicare Set-aside Arrangement (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary file.						X	X	X	X	COBC, ReMAS
5371.1.2	The CWF shall indicate the description name for the MSP code "W" record as 'WC Set-aside'.									X	
5371.1.3	The Medicare shared systems shall accept the description name of 'WC Set-aside" for MSP code "W" records.	X	X	X	X	X	X	X	X		
5371.2	The CWF and contractor shared systems shall accept a new contractor number 11119 on incoming MSP "W" HUSP records for application on the MSP Auxiliary file.						X	X	X	X	COBC
5371.2.1	The shared systems shall accept contractor number 11119, MSP code "W" and source code "19" on returned 03 CWF trailer response.						X	X	X		
5371.2.2	The CWF and the contractor shared systems shall accept a "19" in the source code field on the						X	X	X	X	COBC

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	HUSP and HUSC/HUST transactions for contractor 11119.										
5371.2.3	The CWF shall accept a "Y" Validity Indicator for HUSP transactions created by Contractor 11119.									X	COBC
5371.2.3.1	The shared systems shall accept a "Y" Validity Indicator, as well as MSP code W, for HUSC transactions for Contractor 11119.						X	X	X		COBC
5371.2.4	CWF shall return a '19' in the Source Code field of the Trailer '03' response.									X	
5371.2.5	CWF shall use the following address for contractor number 11119: WCMSA, P.O. Box 33847, Detroit, MI 48232.									X	
5371.3	CWF shall allow Contractors 11100, 11101,11102,11103,11104,11105, 11106, 11107,11108,11109,11110,11111, 11112,11113,11114,11115,11116, 11117, 11118,11125,11126,11140, 33333,55555,77777, 88888, 99999, and 11119 to update, delete, change records originated or updated by contractor 11119.									X	COBC
5371.3.1	CWF shall allow Contractors 11100,11101,11102,11103,11104, 11105,11106,11107,11108,11109, 11110,11111,11112,11113,11114, 11115,11116,11117,11118,11125, 11126,11140,33333,55555,77777, 88888,99999, and 11119 records to be updated, deleted, or changed by contractor 11119.									X	COBC
5371.3.2	CWF will create and send a HUSC transaction to the contractor's shared systems that have processed claims for each beneficiary when an add or change transaction is received for									X	

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	contractor '11119' or from contractor '11119'.										
5371.3.3	The Contractor shared systems shall accept and process HUSC/HUST transactions when an add, change or delete transaction is received for contractor "11119" or from contractor "11119".	X	X	X	X	X	X	X	X		
5371.3.4	The CROWD report shall be updated to reflect special project number "7019" as Workers' Compensation Set-aside Arrangements.	X	X	X	X	X	X	X	X		CROWD
5371.4	The CWF shall apply the same MSP consistency edits for MSP (Workers' Compensation) code E to MSP code W.									X	
5371.5	The Part A contractor system shall continue to accept claims with value code 15 for Part A claims that may be reviewed against an open "W" MSP auxiliary record.						X				
5371.5.1	The Part B and DME MAC contractor shared systems shall continue to accept claims with insurance code 15 in association with an open "W" MSP auxiliary record.							X	X		
5371.6	The CWF maintainer shall create a new utilization error code (6815)- "WCMSA exists. Medicare contractor payment not allowed".									X	
5371.6.1	CWF shall set this error under the following conditions when: • An occurrence on the MSP Auxiliary file exists with a MSP code "W". • A Medicare contractor attempts to pay a claim.									X	
5371.6.2	The shared systems shall accept the new error code (6815) as						X	X	X	X	

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	returned with the 08 trailer.										
5371.6.3	Following receipt of utilization error code 6815, the Medicare contractors systems shall deny all claims (including conditional payment claims) related to the diagnosis codes on the CWF MSP Auxiliary file for MSP code "W", when there is no termination date entered for MSP "W" code.	X	X	X	X	X	X	X			Part B Cap
5371.6.4	Upon denying the claim, all contractor shared systems shall create a "19" Payment Denial Indicator in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, HUDC claims.	X	X	X	X	X	X	X	X		
5371.6.4.1	Upon denying the claim, the indicated contractors and shared systems shall… • populate a "W" in the MSP code field and • in addition to the requirements in 6.4, shall create a "19" in the HUBC and HUDC claim header transaction and a "19" in the claim detail pay process field.	X	X		X			X	X		
5371.6.4.2	Upon denying the claim, the indicated contractors and shared systems shall populate a 15 in the value code field in addition to the requirement provided in 6.4.	X		X		X	X				
5371.7	CWF shall ensure that error code 6815 may be overridden by Medicare contractors, with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. (NOTE: An example of a situation in which Medicare contractors may override claim lines is the billing of code 90658 & G0008 on two claim lines of a multi-line									X	

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claim.)										
5371.7.1	For MSP verification purposes, and prior to overriding claims on which the contractor received error code 6815, the contractor shall: • check CWF to confirm that date of service of the claim is after the termination date of the MSP "W" record; • and confirm the diagnosis code on the claim is related to the diagnosis codes on the MSP W record.	X	X	X	X	X					
5371.8	Carriers/DME MACs' shall override the payable lines with override code N.	X	X		X						
5371.8.1	The FI contractors shall override of the payable claims with override code N.			X		X					
5371.8.1.1	If the claim is to be allowed, a 'N' shall be placed on the '001' Total revenue Charge line of the claim.			X		X					
5371.8.2	The contractor shared systems shall allow an override of the new error code(6815) with code N.						X	X	X		
5371.9	The Comprehensive Error Rate Testing Contractor(CERT) shall accept the MSP code on the claim resolution field(position 465)						X		X		CERT
5371.10	The contractor shared systems shall bypass the MSPPAY module if there is an open MSP code "W".						X	X	X		
5371.11	The CWF will create a new HUSP transaction error code to set when an incoming HUSP transaction with MSP Code 'W' is submitted and the Beneficiary MSP Auxiliary File contains an open MSP occurrence with MSP Code 'E' with the same effective date and diagnosis code(s)".									X	COBC

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5371.11.1	The Medicare contractor and the shared systems shall not make payment for those services related to diagnosis codes associated with the "W" Auxiliary record when the claims date of service is on or after the effective date and before or on the termination date of the record.	X	X	X	X	X	X	X	X		
5371.11.2	The Medicare contractors and the shared systems shall make payment for those services related to diagnosis codes associated with the "W" Auxiliary record when a termination date is entered, and the claims dates of service is after the termination date.	X	X	X	X	X	X	X	X		
5371.12	The Medicare contractors and shared systems shall include Reason code 201 Group code PR, Remark Code MA01, when denying claims based on a "W" MSP auxiliary record on outbound 837 claims.	X	X	X	X	X	X	X			
5371.12.1	The Medicare contractors and shared systems shall utilize Group code PR, Reason Code 201, Remark Code MA01, when denying claims based on a "W" MSP auxiliary record for 835 ERA and SPR messages.	X	X	X	X	X	X	X			
5371.13	The Medicare contractors and shared systems shall afford appeal rights for denied MSP code "W" claims.	X	X	X	X	X	X	X	X		
5371.14	The COBC shall convert existing WCMSA code "E" records to MSP code "W" records.										COBC
5371.15	The Medicare contractors shall generate MSN message 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future	X	X	X	X	X	X	X	X		

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	medical expenses and prescription drug treatment related to your injury (ies) or in Spanish, 29.33 - Su reclamación ha sido denegada por Medicare porque usted podría sacar dinero de su convenio/acuerdo para pagar por sus futuros gastos médicos y su tratamiento con medicinas recetadas relacionadas a su lesión (es).										
5371.16	As part of the provider education requirements below, contractors shall inform providers that a Workers' Compensation Set-aside Arrangement shall be designated on the 271 response with "EB" followed by the qualifier WC.	X	X	X	X	X					
5371.16.1	Those individuals and systems responsible for the 270/271 transaction shall ensure that documentation concerning the EB value and qualifier WC is updated in accordance with 5371.16.										270/271 dedicated staff and systems.

III. PROVIDER EDUCATION TABLE

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5371.17	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information	X	X	X	X	X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Cynthia Gross: (410) 786-3632

Post-Implementation Contact(s): Cynthia Gross, Phone: (410) 786-3632

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

C. For the Coordination of Benefits Contractor and the Medicare Secondary Payer Recovery Contractor:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

80.7 - MSP Maintenance Transaction Error Codes

(*Rev. 1703, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09*)

A3-3810, CWF EditMnts
(http://cms.csc.com/cwf/downloads/docs/pdfs/editmnts.pdf)

MSP Maintenance Transaction edit rejects are denoted by a value of SP in the disposition field on the Reply Record. A Trailer of 08 containing up to four error codes will always follow. Listed below are the possible MSP Maintenance Transaction error codes with a general description.

MSP Maintenance Transaction Error Codes

Error Code	Explanation
SP11	Invalid MSP transaction record type (Mandatory). **Purpose:** To ensure a valid record type: nonblank, "HUSP," "HISP," "HCSP," or "HBSP." **Resolution:** Correct the transaction record type and resubmit.
SP12	Invalid HICN (Mandatory). **Purpose:** To ensure validity for equitable conversion. **Resolution:** Correct the HICN and resubmit.
SP13	Invalid beneficiary Surname (Mandatory). **Purpose:** To ensure a valid format: nonblank, alphabetic. **Resolution:** Verify and correct the beneficiary surname and resubmit.

Error Code	Explanation
SP14	Invalid beneficiary first name initial (Mandatory). **Purpose:** To ensure a valid format: nonblank, alphabetic. **Resolution:** Verify and correct beneficiary first name initial and resubmit.
SP15	Invalid beneficiary date of birth (Mandatory). **Purpose:** To ensure a valid format: nonblank, numeric. **Resolution:** Correct date of birth and resubmit.
SP16	Invalid beneficiary Sex Code (Mandatory). **Purpose:** To ensure only valid values are used: nonblank, must be 0, 1, or 2: 0 = unknown 1 = male 2 = female **Resolution:** Correct sex code and resubmit.
SP17	Invalid contractor number (Mandatory). **Purpose:** To ensure a valid format: nonblank; numeric, must be valid CMS assigned contractor number. **Resolution:** Correct contractor number and resubmit.

Error Code	Explanation
SP18	Invalid document control number. Mandatory for HUSP and HBSP Transactions. Only blank for all others. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; : **Resolution:** Correct DCN and resubmit.
SP19	Invalid maintenance transaction type (Mandatory). **Purpose:** To ensure only valid values are used: nonblank, 0, or 1: 0 = Add/change MSP Data transaction 1 = Delete MSP Data transaction **Resolution:** Correct maintenance transaction type and resubmit.
SP20	Invalid Validity Indicator (Mandatory). **Purpose:** To ensure only valid values are used: nonblank, Y, I, or N: Y = Beneficiary has MSP coverage I = Beneficiary has MSP coverage N = Beneficiary does not have MSP coverage **Resolution:** Correct validity indicator and resubmit.
SP21	Invalid MSP Code (Mandatory).

Error Code	Explanation
	Purpose: To ensure only valid values are used: nonblank, A, B, D, E, F, G, H, I, *or W*: A = Working Aged B = ESRD D = Auto Liability E = Workers Comp F = Federal (Public Health) G = Disabled H = Blank Lung I = Veterans *W = Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)* **Resolution:** Correct MSP code and resubmit.
SP22	Invalid diagnosis Code. **Purpose:** To ensure only valid values are used: Alphabetic, Numeric, Space. All spaces, if not used. **Resolution:** Correct diagnosis code and resubmit.
SP23	Invalid Remarks Code.

Error Code	Explanation

Purpose:

To ensure only valid values are used: 1-3, 01-12, 20-26, 30-44, 50-62, 70-72, and spaces:

01 = Beneficiary retired as of Termination Date.

02 = Beneficiary's employer has less than 20 employees.

03 = Beneficiary's employer has less than 100 employees.

04 = Beneficiary is dually entitled to Medicare, based on ESRD, and age, or ESRD and disability.

05 = Beneficiary is not married.

06 = The Beneficiary is covered under the group health plan of a family member whose employer has less than 100 employees.

07 = Beneficiary's employer has less than 20 employees, and is in a multiple, or multi-employer plan which has elected the working aged exception.

08 = Beneficiary's employer has less than 20 employees, and is in a multiple, or multi-employer plan which has not elected the working aged exception.

09 = Beneficiary is self-employed.

10 = A family member of the Beneficiary is self-employed.

20 = Spouse retired as of Termination Date.

21 = Spouse's employer has less than 20 employees.

22 = Spouse's employer has less than 100 employees.

23 = Spouse's employer has less than 100 employees but is in a qualifying multiple, or multi-employer plan.

24 = Spouse's employer has less than 20 employees, and is multiple, or multi-employer plan which has elected the working aged exception.

25 = Spouse's employer has less than 20 employees, and is multiple, or multi-employer plan which has not elected the working aged exception.

Error Code	Explanation
	26 = Beneficiary's spouse is self-employed.
	30 = Exhausted benefits under the plan.
	31 = Preexisting condition exclusions exist.
	32 = Conditional payment criteria met.
	33 = Multiple primary payers, Medicare is tertiary payer.
	34 = Information has been collected indicating that there is not a parallel plan that covers medical services.
	35 = Information has been collected indicating that there is not a parallel plan that covers hospital services.
	36 = Denial sent by EGHP, claims paid meeting conditional payment criteria.
	37 = Beneficiary deceased.
	38 = Employer certification on file.
	39 = Health plan is in bankruptcy, or insolvency proceedings.
	40 = The Termination Date is the Beneficiary's Retirement Date.
	41 = The Termination Date is the spouse's Retirement Date.
	42 = Potential non-compliance case, Beneficiary enrolled is supplemental plan.
	43 = GHP coverage is a legitimate supplemental plan.
	44 = Termination Date equals Transplant Date.
	50 = Employment related accident.
	51 = Claim denied by workers comp.
	52 = Contested denial.
	53 = Workers compensation settlement funds exhausted.
	54 = Auto accident - no coverage.

Error Code	Explanation
	55 = Not payable by black lung. 56 = Other accident - no liability. 57 = Slipped and fell at home. 58 = Lawsuit filed - decision pending. 59 = Lawsuit filed - settlement received. 60 = Medical malpractice lawsuit filed. 61 = Product liability lawsuit filed. 62 = Request for waiver filed. 70 = Data match correction sheet sent. 71 = Data match record updated. 72 = Vow of Poverty correction. **Resolution:** Correct remarks code and resubmit.
SP24	Invalid insurer type. **Purpose:** To ensure only valid values are used: A-M and spaces: A = Insurance or Indemnity B = GHO C = Preferred Provider Organization (PPO) D = Third Party Administrator arrangement under an Administrative Service Only (ASO) contract without stop loss from any entity. E = Third Party Administrator arrangement with stop loss insurance issued from any entity. F = Self-Insured/Self-Administered.

Error Code	Explanation
	G = Collectively-Bargained Health and Welfare Fund. H = Multiple Employer Health Plan with at least one employer who has more than 100 full and/or part-time employees. I = Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part-time employees. J = Hospitalization Only Plan - A plan which covers only Inpatient hospital services. K = Medical Services Only Plan - A plan which covers only non-Inpatient medical services. M = Medicare Supplemental Plan, MEDIGAP, Medicare Wraparound Plan or Medicare Carve Out Plan. SPACES = Unknown **Resolution:** Correct insurer type and resubmit.
SP25	Invalid insurer name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; : . Spaces if not used. Insurer Name must be present if Validity Indicator = y. **Resolution:** Correct insurer name and resubmit.
SP26	Invalid Insurer Address 1 and/or Address 2. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct insurer address and resubmit.

Error Code	Explanation
SP27	Invalid Insurer City. **Purpose:** To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces if not used. **Resolution:** Correct insurer city and resubmit.
SP28	Invalid Insurer State. **Purpose:** To ensure only valid values are used: alphabetic, spaces if not used. Must match on valid state table. **Resolution:** Correct insurer state and resubmit.
SP29	Invalid Insurer Zip Code. **Purpose:** To ensure only valid values are used: Cannot be low values. If present, the first five positions must be numeric and the last four positions may be spaces. If foreign country, "FC" State code then nine positions may be spaces, if not used. **Resolution:** Correct insurer ZIP code and resubmit.
SP30	Invalid Policy Number. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces if not used. **Resolution:** Correct policy number and resubmit.

Error Code	Explanation
	Other Effective Date coverage edits:
SP31	Invalid MSP Effective Date (Mandatory).
	Purpose:
	To ensure only valid values are used: nonblank, nonzero, numeric. Number of days must correspond with the particular month. MSP Effective Date must be less than, or equal to, the current date.

Error Code	Explanation

If MSP Code = A (Working Aged and Spousal Working Aged), effective date must be the later of:

- January 1, 1983; or
- Calculated date beneficiary turned 65 (first day of month).

If MSP Code = B (ESRD).

Effective date must be the later of:

- October 1, 1981; or
- Prior to the 1st day of the month the beneficiary turns 65.

If MSP Code = D (Auto/No-fault/Liability), effective date must be later than December 5, 1980.

If MSP Code = E (Workers' Compensation), effective date must be later than July 1, 1966.

If MSP Code = F (Federal/Public Health), effective date must be later than July 1, 1966.

If MSP Code = G (Disabled), effective date must be later than January 1, 1987.

If MSP Code = H (Black Lung), effective date must be later than July 1, 1973.

If MSP Code = I (Veterans' Administration), effective date must be later than July 1, 1966.

If MSP Code = L (Liability), effective date must be later than December 1, 1980.

If MSP Code = W (WCMSAs), effective date must be later than July 1, 1966.

Resolution:

Correct MSP effective date and resubmit.

Error Code	Explanation
	Other Termination Date coverage edits:
SP32	Invalid MSP Termination Date must be numeric, may be all zeros if not used, if used, date must correspond with the particular month.
	Purpose:
	To ensure only valid values are used: Must be numeric. May be all zeros, if not used. If used, date must correspond with the particular month. • Must be greater than the MSP effective date by 1 month. If validity indicator is N, then termination date may equal effective date. • Cannot be greater than the current date plus 6 months, except when MSP Code = B. • If MSP effective date is 2/1/90 or later, the termination date cannot exceed the MSP effective date by more than 18 months if MSP Code = B. • If the MSP effective date is prior to 2/1/90, the termination date cannot exceed the MSP effective date by more than 12 months if MSP Code = B. • Cannot be greater than the first day beneficiary turned 65 if the MSP code is B or G. • Termination date must be present on type A, B, or G record when accreting a new record with type A, B, or G.
	Resolution:
	Correct MSP Termination Date and resubmit.
SP33	Invalid patient relationship.
	Purpose:
	To ensure only valid values are used: 01-19:

Error Code	Explanation
	01 = Patient is Insured 02 = Spouse 03 = Natural child, insured has financial responsibility 04 = Natural child, insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor 12 = Cadaver donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured plaintiff 16 = Sponsored dependent 17 = Minor dependent of a minor dependent 18 = Parent 19 = Grandparent **Resolution:** Correct Patient Relationship and resubmit.
SP34	Invalid subscriber first name.

Error Code	Explanation
	Purpose: To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct subscriber first name and resubmit.
SP35	Invalid subscriber last name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct subscriber last name and resubmit.
SP36	Invalid employee ID number. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employee id number and resubmit.
SP37	Invalid payer source code. **Purpose:** To ensure only valid values are used: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, 00, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, or 14. **Resolution:** Correct payer source code and resubmit.
SP38	Invalid employee information data code.

Error Code	Explanation
	Purpose: To ensure only valid values are used: Spaces, if not used. Alphabetic values P, S, M, F: P = Patient S = Spouse M = Mother F = Father **Resolution:** Correct employee information data code and resubmit.
SP39	Invalid employer name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employer name and resubmit.
SP40	Invalid employer address. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employer address and resubmit.
SP41	Invalid employer city. **Purpose:** To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces, if not used.

Error Code	Explanation
	Resolution:
	Correct employer city and resubmit.
SP42	Invalid employer State.
	Purpose:
	To ensure only valid values are used: alphabetic, spaces if not used. Must match on valid State table.
	Resolution:
	Correct employer state and resubmit.
SP43	Invalid employer ZIP code.
	Purpose:
	To ensure only valid values are used: nonzero, all spaces if not used. Must be within valid ZIP code range on ZIP code table. If foreign country, "FC" state code. The first five digits can be zeros and last four can be blanks.
	Resolution:
	Correct employer ZIP code and resubmit.
SP44	Invalid insurance group number.
	Purpose:
	To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used.
	Resolution:
	Correct insurance group number and resubmit.
SP45	Invalid insurance group name.
	Purpose:
	To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces, if not used.

Error Code	Explanation
	Resolution:
	Correct insurance group name and resubmit.
SP46	Invalid prepaid health plan date.
	Purpose:
	To ensure only valid values are used: numeric, number of days must correspond with the particular month.
	Resolution:
	Correct health plan date and resubmit c.
SP47	Beneficiary MSP indicator not on for delete transaction.
	Purpose:
	To ensure proper processing of MSP information.
	Resolution:
	Verify MSP indicator and resubmit if appropriate.
SP48	MSP Auxiliary Record not found for delete data transaction.
	Purpose:
	To notify Host of missing MSP data.
	Resolution:
	Verify MSP applicability and resubmit if appropriate.
SP49	MSP auxiliary occurrence not found for delete data transaction.
	Purpose:
	To notify Host of missing MSP data.
	Resolution:
	Verify MSP applicability and contact Host.
SP50	Invalid function for update or delete. Contractor number unauthorized.

Error Code	Explanation
	Purpose: To ensure correct contractor number is submitted. **Resolution:** Verify contractor number, correct and resubmit.
SP51	MSP Auxiliary Record has 17 occurrences and none can be replaced. **Purpose:** To notify Host when MSP Auxiliary Record has reached its maximum size. **Resolution:** Contact Host.
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B, and G when the Validity Indicator is I or Y. **Purpose:** To ensure only valid Patient Relationship Indicators are used: • MSP code A = 01 Patient 02 Spouse • MSP code B = 01 Patient 02 Spouse 03 Child 04 Natural Child 05 Step Child 18 Parent

Error Code	Explanation
	• MSP code G = 01 Patient 02 Spouse 03 Child 04 Natural Child 05 Step Child 18 Parent **Resolution:** Correct Patient Relationship Code and resubmit.
SP53	The maintenance transaction was for Working Aged EGHP, and there is a Disability EGHP entry on file that has a Termination Date after the Effective Date on the incoming transaction, or is not terminated, and the Contract Number on the maintenance transaction is not equal to 11102, 11104, 11105, 11106, 33333, 66666, 77777, or 88888. **Purpose:** To ensure overlapping MSP records are not created. **Resolution:** Verify dates and resubmit.
SP54	MSP Code A, B, or G has an effective date that is in conflict with the date the beneficiary attained age 65. For MSP Code A, the effective date must not be prior to the date the beneficiary attains age 65. For MSP Code B and G, the effective date must not be later than the date the beneficiary attains age 65. **Purpose:** To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit.

SP55 MSP effective date is prior to beneficiary's Part A or Part B entitlement dates.

Purpose:

To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit.

SP56 MSP PHP Date must be equal to, or greater than, MSP Effective Date, or less than MSP Termination Date.

Purpose:

To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit.

SP57 Termination Date is greater than six months prior to date added for Contractor Numbers other than "11100-11114," "33333," "55555," "77777," "88888," or "99999."

Purpose:

To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit or contact Host.

SP58 Invalid Insurer Type, MSP Code, and Validity Indicator combination.

Purpose:

To ensure that codes do not contradict each other.

Resolution:

Verify Insurer Type, MSP Code, and Validity Indicator. Resubmit.

SP59 Invalid Insurer type, and Validity Indicator combination.

Purpose:

To ensure that codes do not contradict each other.

Resolution:

Verify Insurer Type and Validity Indicator. Resubmit.

SP60 Other Insurer Type for same period on file (Non J or K), Insurer Type on incoming maintenance record is equal to J, or K, and Insurer Type on matching Auxiliary record is not equal to J, or K.

Note: Edit applies only to MSP codes

A - Working Aged

B - ESRD EGHP

G - Disability EGHP

Purpose:

To ensure proper processing of MSP information.

Resolution:

Verify Insurer Type and resubmit.

SP61 Other Insurer type for same period on file (J or K) Insurer type on incoming maintenance record is not equal to J or K, and Insurer type on matching Aux. record is equal to J or K.

Note: Edit applies only to MSP codes

A - Working Aged

B - ESRD EGHP

G - Disability EGHP

Purpose:

To ensure proper processing of MSP information.

Resolution:

Verify Insurer Type and resubmit.

SP62 Incoming Term Date is less than MSP Effective Date.

Purpose:

To ensure that MSP record effective dates are accurate.

Resolution:

Verify dates and resubmit.

SP66 MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file.

Purpose:

To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit.

SP67 Incoming Term Date is less than posted Term Date for Provident.

Purpose:

To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.

Resolution:

Verify dates and resubmit.

SP72 Invalid Transaction attempted. A HUSP add transaction is received from a FI or carrier (non-COB Contractor) with a Validity Indicator other than I.

Purpose:

To ensure that correct information is recorded on the MSP Auxiliary record.

Resolution:

Correct Validity Indicator and resubmit.

SP73 Invalid Term Date/Delete Transaction attempted. An FI or carrier is attempting to change a Term Date on a MSP Auxiliary record with a I or Y Validity Indicator that is already terminated.

Purpose:

To ensure that MSP transactions are processed correctly.

Resolution:

Verify segment to delete, correct and resubmit if necessary.

SP74 Invalid, cannot update I record.

Purpose:

To ensure that MSP transactions are processed correctly.

Resolution:

Reject transaction.

SP75 Invalid transaction, no Medicare Part A benefits.

Purpose:

To ensure that Medicare pays only for claims for those who are entitled to Medicare benefits.

Resolution:

Reject transaction.

SP76 *An Auxiliary MSP Workers' Compensation Medicare Set-Aside (WCMSA) MSP Code 'W' record is attempting to be added to CWF and an open Workers' Compensation 'E' record with the same effective date and diagnosis codes exits.*

Purpose

To ensure that Medicare duplicate WCMSA records are not posted to CWF.

Resolution

Reject Transaction.