Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) CWF Process

Table of Contents
(Rev. 43, 10-31-05)

10 - General Information
(Rev. 1, 10-01-03)

Fiscal intermediaries and carriers obtain information pertinent to the identification of MSP for each beneficiary via the CWF, MSP auxiliary file. The auxiliary file is associated with the beneficiary's master record within CWF.

The Coordination of Benefits (COBC) contractor completes MSP updates on a daily basis upon receipt of notice that another payer is primary to Medicare (e.g., an explanation of benefits, a beneficiary questionnaire, a notice from a third party payer, etc.). Every claim for a given beneficiary is validated against the same MSP data housed in a CWF, MSP auxiliary file, thus permitting uniform processing. Contractor claims data inconsistent with a CWF, MSP auxiliary file will cause rejects and/or error conditions. An MSP auxiliary record consistent with an identified MSP situation must be present before a payment is approved for an MSP claim. An MSP auxiliary record is established by an MSP maintenance transaction submitted to CWF. The claim must agree with the MSP auxiliary record that was established, or it will not process.

The COBC is the source for establishing new MSP records, with the exception of four situations described in §10.1, below. The COBC submits MSP maintenance transactions on the basis of information obtained outside the claims process. Examples include IEQ, IRS/SSA/CMS Data Match, voluntary MSP data match agreements, attorney, beneficiary, provider information, and 411.25 Notices. The COBC also submits MSP maintenance transactions based on First Claim Development (FCD) and Trauma Code Development (TCD).

10.1 - Overview of CWF MSP Processing
(Rev. 1, 10-01-03)

The CWF, MSP auxiliary file is updated with maintenance transactions from the Coordination of Benefits Contractor (COBC), except for the following situations:

1. If the contractor receives a phone call or correspondence from an attorney/other beneficiary representative, beneficiary, third party payer, provider, another insurer’s Explanation of Benefits (EOB) or other source that establishes, exclusive of any further required development or investigation, that MSP no longer applies, it must add termination dates to MSP auxiliary records already established by the COB on CWF with a "Y" validity indicator where there is no discrepancy in the validity of the information contained on CWF. (See §20.1.4)

2. If the intermediary or carrier receives a claim for secondary benefits and could, without further development (for example, the EOB from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim, it submits a validity indicator of "I" to add any new MSP occurrences (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). It shall update CWF within 10

calendar days from completion of the evaluation. It cannot submit a new record with a "Y" or any record with an "N" validity indicator.

3. If the intermediary or carrier receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development, it must add the MSP occurrence using an "I" validity indicator (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). It shall update CWF within 10 calendar days from completion of the evaluation.

It shall transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. "I" records should only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will be rejected with an SP 20 error code. Receipt of an "I" validity indicator will result in a CWF trigger to the COBC. The COBC will develop and confirm all "I" maintenance transactions established by the intermediary or carrier. If the COBC has not received information to the contrary within 100 calendar days, the COBC will automatically convert the "I" validity indicator to a "Y". If the COBC develops and determines there is no MSP, the COBC will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to the intermediary or carrier on its claim attachment or unsolicited refund documentation. If the intermediary or carrier has the actual date that Medicare became secondary payer, it shall use that as the MSP effective date. If that information is not available, it shall use the Part A entitlement date as the MSP effective date. It may include a termination date when it initially establishes an "I" record. It may not add a termination date to an already established "I" record.

Prior to April 1, 2002, intermediaries and carriers post MSP records to CWF where beneficiaries were entitled to Part B benefits, but not entitled to Part A benefits. An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF edits to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. If a contractor submits an Electronic Correspondence Referral System (ECRS) transaction to the coordination of benefits (COBC) contractor to add a GHP MSP record where there is no Part A entitlement, reason code of 61 will be returned. Intermediaries and carriers should not submit an ECRS request to COBC to establish a GHP MSP record when there is no Part A entitlement. Contractors that attempt to establish an "I" record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A entitlement when non-employer GHP situations exists, such as automobile, liability, and workers' compensation. Where a non-employer GHP situation exists, intermediaries and carriers should continue to submit ECRS transactions and establish "I" records, as necessary.

MSP Auxiliary maintenance transactions, for the four situations listed above, and claims for payment approval may be submitted to CWF in the same file. The CWF processes the MSP maintenance transactions before processing claims. This procedural flow is to assure processing for claim validation against the most current MSP data. If the MSP claim is accepted, the CWF host will return all MSP data on a beneficiary's auxiliary file to the submitting contractor via an "03" trailer. If the claim is rejected, the host will return only those MSP records that fall within the dates of service on the claim. A maximum of 17 MSP auxiliary records may be stored in CWF for each beneficiary. The validity indicator field of each CWF, MSP auxiliary record indicates confirmation that:

- Another insurer is responsible for payment ("Y" in the field); or
- Medicare is the primary payer ("N" in the field, IEQ record).

Medicare contractors may access the MSP auxiliary file through the online CWF file display utility Health Insurance Master Record (HIMR).

Intermediaries and carriers cannot delete MSP auxiliary records. They send such requests to the COB via the Electronic Correspondence Referral System (ECRS). (See Chapter 5, §§10.)

10.2 - Definition of MSP/CWF Terms

(Rev. 43, Issued: 10-31-05; Effective Date: 04-01-06; Implementation Date: 04-03-06)

Following is a list of terms and their definitions used in MSP/CWF processing.

MSP Auxiliary File - Up to 17 beneficiary MSP occurrences/records on the CWF database.

MSP Auxiliary Record - Record of beneficiary MSP information. One MSP record/occurrence within the beneficiary's MSP auxiliary file.

Occurrence - One MSP occurrence/record within the beneficiary's MSP auxiliary file.

MSP Effective Date - Effective date of MSP coverage.

MSP Termination Date - Termination date of MSP coverage.

Validity Indicator

- Y - Beneficiary has MSP coverage (there is a primary insurer for this period of time).
- N - No MSP coverage

- I - See §10.1.

MSP Types - Reason for other coverage entitlement.

- A = Working Aged
- B = End stage renal disease (ESRD)
- D = Automobile/Liability No-Fault
- E = Workers' Compensation (WC)
- F = Federal, Public Health
- G = Disabled
- H = Black Lung (BL)
- I = Veterans Affairs (VA)
- L=Liability

NOTE: VA and other Federal payments are exclusions rather than MSP nonpayments.

Cost Avoided Claim - A claim returned without payment because CWF indicators indicate another insurer is primary to Medicare. (See Chapter 5, §60 for complete description.)

Transaction Type - Identifies type of maintenance record.

- 0 = Transaction type to add or change MSP data
- 1 = Transaction type to delete MSP data

Override Code - Code used to bypass CWF, MSP edit to allow primary Medicare payment. (See §40.4 for a detailed explanation.)

COB MSP Contractor Numbers

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
	33333 = Litigation Settlement	V	4000
P	55555 = HMO Rate Cell Adjustment	U	3000

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
B, D, T, U, V, or W	77777 = IRS/SSA/HCFA Data Match (I, II, III, IV, V, or VI)	Y	1000
Q	88888 = Voluntary Data Sharing Agreements	Q	5000
O	99999 = Initial Enrollment Questionnaire	T	2000

COB Contractor Numbers prior to January 1, 2001

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = COB Contractor		6000
1	11101 = Initial Enrollment Questionnaire	K	6010
2	11102 = IRS/SSA/CMS Data Match	E	6020
3	11103 = HMO Rate Cell	F	6030
4	11104 = Litigation Settlement	G	6040
5	11105 = Employer Voluntary Reporting	H	6050
6	11106 = Insurer Voluntary Reporting	H	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary Claims Investigation	G	6090
X	11110 = Self Reports	H	7000
Y	11111 = 411.25	J	7010

NOTE: Effective January 1, 2001, the following COB Contractor numbers and nonpayment/payment denial codes will be used.

COB Contractor Numbers Effective January 1, 2001

CWF Source Codes	COB Contractor Numbers	Nonpayment / Payment Denial Codes	CROWD Special Project Numbers
0	11100 = COB Contractor	00 Effective 4/1/2002	6000
1	11101 = Initial Enrollment Questionnaire	T	6010
2	11102 = IRS/SSA/CMS Data Match	Y	6020
3	11103 = HMO Rate Cell	U	6030
4	11104 = Litigation Settlement	V	6040
5	11105 = Employer Voluntary Reporting	Q	6050
6	11106 = Insurer Voluntary Reporting	K	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary claims Investigation	G	6090
10 - Effective 4/1/2002	11110 = Self Reports	H	7000
11 - Effective 4/1/2002	11111 = 411.25	J	7010

11101, 11102, 11103, 11104, and 11105 use the same non-payment denial codes as their previous contractor numbers (i.e., 33333, 55555, 77777, 88888, 99999). Savings from the old and new numbers, if applicable will be reported together (e.g., 11101 and 99999, etc). There must be a conversion of the MSP savings to the new non-payment/payment denial codes as of January 1, 2001.

Additional COB Contractor Numbers Effective April 1, 2002

Effective April 1, 2002, CWF is expanding the source code field and the nonpayment/ payment denial code field from 1-position fields to 2-position fields.

CWF Source Codes	COB Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
12	11112 = Blue Cross-Blue Shield Voluntary Data Sharing Agreements	12	7012
13	11113 = Office of Personnel Management (OPM) Data Match	13	7013
14	11114 = *State* Workers' Compensation (WC) Data Match	14	7014
15	*11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)*	*15*	*7015*
16	*11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)*	*16*	*7016*
17	*11117 = Voluntary Data Sharing Agreements (No Fault VDSA)*	*17*	*7017*
18	*11118 = Pharmacy Benefit Manager Data*	*18*	*7018*
19	11119 = To be determined	19	7019
20	11120 = To be determined	20	7020
""	""	""	""
25	11125 = Recovery Audit Contractor-California	25	7025
26	11126 = Recovery Audit Contractor-Florida	26	7026
27	11127 = To be determined	27	7027
""	""	""	""
99	11199 = To be determined	99	7099

20 - MSP Maintenance Transaction Record Processing

(Rev. 1, 10-01-03)

The COBC shall submit an MSP maintenance transaction to establish an MSP auxiliary record within 10 calendar days of receipt of notice that another payer is primary to Medicare. The CWF applies extensive editing to the maintenance transaction. If an MSP maintenance transaction does not meet all edit criteria, error codes specific to the failed edit(s) will be returned via the CWF, MSP Maintenance Transaction Response. A complete record layout and field descriptions are contained in CWF Systems Documentation, Record Name: CWF, MSP Maintenance Transaction Response. For Out-of-Service Area transactions, the CWF OSA Maintenance Transaction Response is used. Its complete record layout and field descriptions are contained in CWF Systems Documentation, Record Name: CWF, MSP Maintenance Transaction Response. The consistency edit error codes and edit definitions are contained in CWF Systems Documentation Record Name: MSP Maintenance Transaction Error Codes. MSP transactions that pass all edits are applied to the CWF, MSP auxiliary file.

20.1 - Types of MSP Maintenance Transactions
(Rev. 1, 10-01-03)

The three types of maintenance transactions are add, change, and delete.

The COBC shall use MSP maintenance transaction type "O" (zero) for an add or a change transaction.

- The transaction is an add when no matching MSP occurrence - NO MATCHING MSP auxiliary record - is found for the beneficiary;

- The transaction is a change when a matching MSP occurrence is found.

After a successful MSP maintenance transaction processes through CWF, before and after images of the MSP auxiliary file occurrence are written to the MSP Audit File.

20.1.1 - MSP Add Transaction
(Rev. 8, 2-6-04)

The two situations in which the "add" maintenance transaction is used are:

- There is no MSP auxiliary file record for a beneficiary. In this case, the "add" transaction creates an MSP auxiliary record containing the new MSP transaction and sets the MSP indicator on the beneficiary's master record; or

- There is an MSP auxiliary file record but no matching occurrence for the beneficiary. In this case, the "add" transaction adds the maintenance transaction as a new occurrence.

The following fields are mandatory for a validity indicator of "Y" or "I" (Another insurer is responsible for payment):

- HICN;
- MSP type (MSP code);
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name (CWF will allow a space in the second position provided the third position contains a valid character other than a space.);
- Patient relationship; and
- Insurance type.

A "Y" or "I" record CANNOT be established without the insurer name.

NOTE: Although the insurer address cannot be MANDATORY, it should be provided whenever possible.

20.1.2 - MSP Change Transaction
(Rev. 8, 2-6-04)

An MSP change transaction occurs when the MSP type and effective date on the incoming maintenance transaction matches an existing MSP auxiliary occurrence.

A match occurs when the following items are the same:

- HICN
- MSP type;
- MSP effective date;
- Insurance type J & K; and
- Patient relationship

When these items match, the balance of the record is overlaid.

No change transactions will be permitted to records established, except for the addition of a termination date.

20.1.3 - MSP Delete Transaction

(Rev. 43, Issued: 10-31-05; Effective Date: 04-01-06; Implementation Date: 04-03-06)

The MSP maintenance type "1" is used to delete an MSP auxiliary occurrence. This transaction checks the beneficiary's master record for an MSP indicator. The COBC is responsible for submitting this transaction. Medicare contractors advise the COBC, via the ECRS, of the need to process an MSP maintenance type 1 transaction (delete).

Only some COBC contractor numbers may delete other originating COBC contractor numbers. Please see the table below for the exact criteria for deletion of COBC contractor numbers. A match shall occur in order to delete the originating COBC contractor number with another COBC contractor number. For example, COBC contractor number 11100, 11109, 11110, 11111, and 11112 are the only contractor numbers that may delete originating COBC contractor number 11112. The COBC will remain the sole contractor that may delete COBC contractor numbers. Medicare contractors shall follow the current restrictions regarding deletion of MSP records.

Originating Contractor	Can be deleted by contractor:
11100	11100
11101, 99999	11100, 11101, 11102, 11109, 11110, 11111
11102, 77777	11100, 11102, 11109, 11110, 11111
11103, 55555	11100, 11103, 11109, 11110, 11111
11104, 33333	11100, 11104, 11109, 11110, 11111, 11112
11105	11100, 11105, 11109, 11110, 11111
11106	11100, 11106, 11109, 11110, 11111
11107	11100, 11107, 11109, 11110, 11111
11108	11100, 11108, 11109, 11110, 11111
11109	11100, 11109, 11110, 11111
11110	11100, 11109, 11110, 11111
11111	11100, 11109, 11110, 11111
11112	11100, 11109, 11110, 11111, 11112
11113	11100, 11109, 11110, 11111, 11113

11114	11100, 11109, 11110, 11111, 11114
11115	*11100, 11109, 11110, 11111, 11115*
11116	*11100, 11109, 11110, 11111, 11116*
11117	*11100, 11109, 11110, 11111, 11117*
11118	*11100, 11109, 11110, 11111, 11118*
66666	11100, 11109, 11110, 11111
11125	11100, 11125
11126	11100, 11126

20.1.4 - MSP Termination Date Transaction
(Rev. 1, 10-01-03)

Intermediaries and carriers add termination dates to MSP auxiliary records already established on CWF with a "Y" validity indicator, where there is no discrepancy in the validity of the information contained on CWF. They handle phone calls and written inquiries relating to simple terminations of existing MSP occurrences. Simple terminations are defined as terminations that can be made to a MSP auxiliary record without further development or investigation. They shall not transfer these calls or written inquiries to the COBC. In determining whether a call is to be handled by them or the COBC, the intermediary or carrier establishes the basis of the call. The following are examples when **not** to transfer a termination request to the COBC for further action.

EXAMPLE 1:

Scenario: Mr. Doe is calling to report that his employer group health coverage has ended.

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates, if no conflicting data are presented. The intermediary/carrier does not transfer the call to the COBC.

EXAMPLE 2:

Scenario: Mrs. X is calling to report that she has retired.

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates if no conflicting data are presented. The intermediary/carrier does not transfer the call to the COBC.

EXAMPLE 3:

Scenario: The intermediary/carrier receives written correspondence that benefits are exhausted for an automobile case.

Intermediary/Carrier Action: The intermediary/carrier checks for matching auxiliary record on CWF. The lead contractor terminates in accordance with existing guidelines (e.g., accounting of monies spent). The non-lead contractor refers the case to the lead contractor based on pre-COB guidelines as outlined in the fiscal year (FY) 2001 MSP post pay Budget and Performance Requirements (BPRs). It does not forward the correspondence to the COBC.

EXAMPLE 4

Scenario: Union Hospital is calling to report that the MSP period contained on CWF for beneficiary X should be terminated.

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates if no conflict in evidence is presented. It does not transfer the call to the COBC.

COBC Role

The COBC adds termination dates to records not covered in A, above. In addition, the COBC updates MSP occurrences as a result of a request from an intermediary or carrier, or as a result of COB development and investigation. The following are examples of when to transfer a termination request to the COBC for further action.

EXAMPLE 1:

Scenario: The termination date is greater than six months prior to the date of accretion (i.e., SP 57 error code) for all COBC numbers (e.g., 11100-11111, 33333, 77777, 88888, or 99999). (All COBC numbers follow the old data match 6-month termination rule.)

Intermediary/Carrier action: The intermediary/carrier sends a CWF assistance request to the COBC.

COBC action: The COBC checks for matching record on CWF and terminates. In cases where discrepant information exists, the COBC will investigate to determine the proper course of action.

EXAMPLE 2:

Scenario: The intermediary/carrier receives information with regard to termination that is discrepant with the information contained on CWF.

Intermediary/Carrier action: The intermediary/carrier forwards to the COBC for investigation via ECRS.

COBC action: The COBC checks for matching record on CWF, investigates, and terminates if appropriate.

20.2 - Medicare Secondary Payer (MSP) Maintenance Transaction Record/Fiscal Intermediary (FI) and Carrier MSP Auxiliary File Update Responsibility

(Rev.)

Effective January 1, 2001, the capability to update the CWF Medicare Secondary Payer (MSP) auxiliary file is essentially a function of only the Coordination of Benefits Contractor (COBC). Carriers and Fiscal Intermediaries (FIs) will not have the capability to delete any MSP auxiliary file records, including those that a specific carrier or FI has established. If it is believed that a record should be changed or deleted, carriers and FIs use the COB Contractor Electronic Correspondence Referral System (discussed in the Medicare Secondary Payer (MSP) Manual, Chapters 4 and 5, CWF Assistance Request option, to notify the COB Contractor. Carriers and FIs process claims in accordance with existing claims processing guidelines.

There are only four instances in which carriers and FIs will retain the capability to update CWF. They are:

A. A claim is received for secondary benefits and the contractor could, without further development (for example, the EOB from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim. Carriers and FIs must use a new validity indicator of "I" to add any new MSP occurrences, and update CWF within 10 calendar days from completion of the evaluation. Carriers and FIs cannot submit a new record with a "Y" or any record with an "N" validity indicator.

B. A claim is received for conditional payment, and the claim contains sufficient information to create an "I" record without further development. Carriers and FIs add the MSP occurrence using an "I" validity indicator. They must update CWF within 10 calendar days from completion of the evaluation.

C. It is determined that an unsolicited refund is MSP based, and the referral document contains sufficient information to create an "I" record without further development. Carriers and FIs add the MSP occurrence using an "I" validity indicator. They update CWF within 10 calendar days from completion of the evaluation.

D. A phone call or correspondence is received from an attorney or other beneficiary representative, beneficiary, third party payer, provider, another insurer's Explanation of Benefits (EOB) or other source that establishes, exclusive of any

further required development or investigation that MSP no longer applies. Examples of such contacts include a telephone call from a beneficiary to report retirement or cessation of group health insurance or a letter that contains acceptable information that personal injury protection benefits have been exhausted. Carriers and FIs add a termination date to the MSP auxiliary record using a "Y" validity indicator. They update CWF within the lesser of:

1. 10 calendar days from completion of the evaluation, or

2. 30 calendar days of the mailroom date stamped receipt/date of phone call, as applicable. Carriers and FIs do not have the capability to alter an existing termination date.

Carriers and FIs will transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. Receipt of an "I" validity indicator will result in a CWF trigger to the COB Contractor. The COB Contractor will develop and confirm all "I" maintenance transactions established by carriers and FIs. If the COB Contractor has not received information to the contrary within 100 calendar days, the COB Contractor will automatically convert the "I" validity indicator to a "Y." If the COB Contractor develops and determines there is no MSP, the COB Contractor will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to a carrier or FI on a claim attachment or unsolicited refund documentation. If they have the actual date that Medicare became secondary payer, they use that as the MSP effective date. If that information is not available, they use the Part A entitlement date as the MSP effective date. Carriers and FIs may include a termination date when they initially establish an "I" record. They may not add a termination date to an already established "I" record.

Effective January 1, 2003, CWF accepts an "I" record only if no MSP record (validity indicator of either "I" or "Y;" open, closed or deleted status) with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will reject with an SP 20 error code. The resolution for these cases is to transfer **all** available information to the COBC via the Electronic Correspondence Referral System (ECRS) CWF assistance request screen. It will be the responsibility of the COBC to reconcile the discrepancy and make any necessary modifications to the CWF auxiliary file record.

In addition, effective January 1, 2003, a refund or returned check is no longer a justification for submission of an "I" record. Since an "I" record does not contain the source (name and address) of the entity that returned the funds, COBC lacks the information necessary to develop to that source. Follow the examples below to determine which ECRS transaction to submit:

1. An MSP inquiry should be submitted when there is no existing or related MSP record on the CWF.

2. The CWF assistance request should be submitted when the information on the CWF is incorrect or the MSP record has been deleted.

3. If the check or voluntary refund will open and close the case/MSP issue, the carrier or FI should submit an MSP inquiry. They should refer to ECRS 5.0 manual for more information regarding closed cases.

The check should be deposited to unapplied cash until COBC makes an MSP determination.

30 - CWF, MSP Auxiliary File
(Rev. 1, 10-01-03)

A maximum number of 17 MSP auxiliary records may be stored in CWF for each beneficiary. The COBC is responsible for deletion of a record when the maximum storage is exceeded using the following priority:

- Oldest "deleted" (flagged for deletion) occurrence;
- Oldest "confirmed no" occurrence;
- Oldest termination date; or
- Oldest maintenance date for the MSP type to be added.

30.1 - Integrity of MSP Data
(Rev. 1, 10-01-03)

The CWF MSP data base integrity is totally dependent upon COBC input, supported by input by FIs and carriers to the COBC. The COBC is responsible for submitting to CWF MSP information it believes to be of the highest quality. It shall investigate information thoroughly before making changes to an existing CWF MSP auxiliary record.

Intermediaries and carriers shall update their internal MSP control file with the information received via the CWF "03" trailer response. If more current information is available that conflicts with that received from CWF, the contractor is responsible for advising the COBC, via ECRS, of the need to correct the CWF, MSP auxiliary record.

30.1.1 - Maintenance and Clean-Up of MSP Auxiliary files in CWF
(Rev. 1, 10-01-03)

1998 MSP BPRs for MSP

As a result of MSP litigation settlement agreements CMS negotiated, records were added to the MSP Auxiliary file under contractor number 33333 (litigation settlement). Under

the settlement agreements, CMS was to receive records for only those Medicare beneficiaries for which Medicare was secondary payer per a settlement agreement However, some data provided to CMS contain records for Medicare beneficiaries covered under a retirement group health plan or supplemental plan. These records were added to the CWF, MSP Auxiliary File. As these erroneous records are identified, beneficiaries, providers and the primary health plan have been notifying contractors that the records need to be corrected to again reflect Medicare as primary. All MSP Auxiliary File records, including these litigation records, need to be corrected and complete to maintain the integrity of the MSP Auxiliary File. As they become aware of an erroneous record, intermediaries and carriers are to advise the COBC via ECRS.

30.1.2 - MSP Effective Date Change Procedure
(Rev. 1, 10-01-03)

When the COBC becomes aware that an MSP effective date is incorrect, it shall perform the following functions:

- Delete the auxiliary record containing the incorrect MSP effective date using an MSP delete transaction; and

- Submit a CWF, MSP maintenance transaction with the correct MSP effective date to establish a new auxiliary record.

NOTE: When the beneficiary is entitled to both Parts A and B, the COBC shall use the Part A entitlement date, if the insurance effective date is prior to entitlement to Medicare.

30.1.3 - CWF/MSP Transaction Request for Contractor Assistance
(Rev. 1, 10-01-03)

Instances occur when the intermediary or carrier determines that the MSP effective date is not correct. When this happens, the contractor shall advise the COB, via ECRS, of the need to change the MSP effective date and shall provide the COBC with documentation to substantiate the change.

30.2 - MSP Termination Date Procedure
(Rev. 1, 10-01-03)

A. Future Termination Dates

The CWF allows future termination dates up to six months for all MSP types, except ESRD. For ESRD, CWF uses the following criteria:

- MSP effective date prior to February 1, 1990, allows for termination date up to 12 months after the effective date;

- MSP effective date February 1, 1990, through February 29, 1996, allows for termination date up to 18 months after the effective date; or

- MSP effective date March 1, 1996, and later allows for termination date up to 30 months after the effective date.

B. Add Termination Dates

A termination date can only be added (not changed) to MSP auxiliary records established by contractor number "77777" or by contractor numbers "11101-11106."

C. Termination for "Y" Validity Indicator

A CWF MSP auxiliary record with a "Y" validity indicator establishes Medicare as the secondary payer. When posting a termination date to this record the "Y" validity indicator should not be changed. The record indicates a valid MSP occurrence and all future claims submitted will edit against the time frame posted. The contractor shall advise the COBC via ECRS when MSP no longer applies, and the COBC shall enter the termination date.

30.3 - MSP Auxiliary File Errors
(Rev. 1, 10-01-03)

CWF Documentation 7/2002 Release, PM AB-98-16, A3-3810
Maintenance transactions to the MSP Auxiliary file reject invalid data with errors identified 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. See CWF documentation at http://cms.csc.com/cwf/ for more specific information. Listed below are the possible MSP Maintenance Transaction error codes with a general description.

Error Code	Definition	Valid Values
SP11	Invalid MSP transaction record type	"HUSP", "HISP" or "HBSP"
SP12	Invalid HIC Number	Valid HIC Number
SP13	Invalid Beneficiary Surname	Valid Surname
SP14	Invalid Beneficiary First Name Initial	Valid Initial
SP15	Invalid Beneficiary Date of Birth	Valid Date of Birth
SP16	Invalid Beneficiary Sex Code	0=Unknown, 1=Male, 2=Female
SP17	Invalid Contractor Number	CMS Assigned Contractor Number

Error Code	Definition	Valid Values
SP18	Invalid Document Control Number	Valid Document Control Number
SP19	Invalid Maintenance Transaction Type	0=Add/Change MSP Data transaction, 1=Delete MSP Data Transaction
SP20	Invalid Validity Indicator	Y= Beneficiary has MSP Coverage, I= Entered by intermediary/ carrier - Medicare Secondary-COB investigate, N -No MSP coverage
SP21	Invalid MSP Code	A=Working Aged B=ESRD C= Conditional Payment D= No Fault E= Workers' Compensation F= Federal G= Disabled H= Black Lung I= Veteran's Administration L= Liability
SP22	Invalid Diagnosis Code 1-5	Valid Diagnosis Code
SP23	Invalid Remarks Code 1-3	See the Valid Remarks Codes Below
SP24	Invalid Insurer Type	A thru M and spaces are valid. See Definitions of Insurer Type Codes Below.
SP25	Invalid Insurer Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; : Insurer Name must be present if Validity Indicator = Y

Error Code	Definition	Valid Values
	An SP25 error is returned when the MSP Insurer Name is equal to one of the following: • Supplement • Supplemental • Insurer • Miscellaneous • CMS • Attorney • Unknown • None • N/A • Un • Misc • NA • NO • BC • BX • BS • BCBX • Blue Cross • Blue Shield • Medicare	
SP26	Invalid Insurer Address 1 and/or Address 2	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP27	Invalid Insurer City	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP28	Invalid Insurer State	Must match U.S. Postal Service state abbreviation table.
SP29	Invalid Insurer Zip Code	If present, 1st 5 digits must be numeric. If foreign country "FC" state code, the nine positions may be spaces.
SP30	Invalid Policy Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP31	Invalid MSP Effective Date (Mandatory)	Non-blank, non-zero, 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	**Definition**	**Valid Values**
SP32	Invalid MSP Termination Date	Must be numeric; may be all zeroes if not used; if used, date must correspond with the particular month.
SP33	**Invalid Patient Relationship**	**See Valid Values Below:**
	Patient Relationship	**Valid Values**
	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

Error Code	Definition	Valid Values
	18	Parent
	19	Grandparent
SP34	Invalid subscriber First Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP35	Invalid Subscriber Last Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP36	Invalid Employee ID Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP37	**Invalid Source Code**	**A through W and Spaces are valid. See source codes and definitions below:**
	Source Code	**Valid Values**
	A	Claim Processing
	B	IRS/SSA/CMS Data Match
	C	First Claim Development
	D	IRS/SSA/CMS Data Match II
	E	Black Lung (DOL)
	F	Veterans (VA)
	G	Other Data Matches
	H	Worker's Compensation
	I	Notified by Beneficiary
	J	Notified by Provider
	K	Notified by Insurer
	L	Notified by Employer
	M	Notified by Attorney

Error Code	Definition	Valid Values
	N	Notified by Group Health Plan/Primary Payer
	O	Initial Enrollment Questionnaire
	P	GHO Rate Cell Adjustment
	Q	Voluntary Insurer Reporting
	R	Office of Personnel Management Data Match
	S	Miscellaneous Reporting
	T	IRS/SSA/CMS Data Match III
	U	IRS/SSA/CMS Data Match IV
	V	IRS/SSA/CMS Data Match V
	W	IRS/SSA/CMS Data Match VI
	00	Coordination of Benefits Contractor (COBC)
	1	Initial Enrollment Questionnaire
	2	IRS/SSA/CMS Data Match
	3	HMO Rate Cell
	4	Litigation Settlement
	5	Employer Voluntary Reporting
	6	Insurer Voluntary Reporting
	7	First Claim Development
	8	Trauma Code Development
	9	Secondary Claims Investigation
	10	Self Reports
	11	411.25
	12	Blue Cross and Blue Shield Voluntary Data Sharing

Error Code	Definition	Valid Values
		Agreement
	13	Office of Personnel Management (OPM) Data Match
	14	Workers' Compensation (WC) Data Match
	SPACES	Unknown
SP38	Invalid Employee Information Data Code	Spaces if not used, alphabetic values P, S, M, F. See §30.3.4 for definition of each code.
SP39	Invalid Employer Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP40	Invalid Employer Address	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP41	Invalid Employer City	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP42	Invalid Employer State	Must match U.S. Postal Service state abbreviations.
SP43	Invalid Employer ZIP Code	If present, 1st 5 digits must be numeric. If foreign country ‘FC’ is entered as the state code, and the nine positions may be spaces.
SP44	Invalid Insurance Group Number	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP45	Invalid Insurance Group Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP46	Invalid Pre-paid Health Plan Date	Numeric; number of days must correspond with the particular month.
SP47	Beneficiary MSP indicator not on for delete transaction.	Occurs when the code indicating the existence of MSP auxiliary record is not equal to "1" and the MSP maintenance transaction type is equal to ‘1’.
SP48	MSP auxiliary record not	See MSP Auxiliary Record add/update and delete

Error Code	Definition	Valid Values
	found for delete data transaction	function procedures above.
SP49	MSP auxiliary occurrence not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP50	Invalid function for update or delete. Contractor number unauthorized	See MSP Auxiliary Record add/update and delete function procedures above
SP51	MSP Auxiliary record has 17 occurrences and none can be replaced	
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B and G when the Validity Indicator is "Y"	Valid Patient Relationship codes associated with MSP codes are listed below
	MSP Codes and associated Patient Relationship Codes:	
	MSP Code	Patient Relationship Code
	A - Working Aged	01 - Patient, 02 - Spouse
	B - ESRD	01 - Patient, 02 - Spouse, 03 - Child, 04 - Natural Child, 05 - Step child, 18 - Parent
	G - Disabled	01 - Patient, 02 - Spouse, 03 - Child, 04 - Natural Child, 05 - Step child, 18
SP53	The maintenance transaction was for Working Aged EGHP and there is either a ESRD EGHP or 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", "88888", or "99999".	

Error Code	Definition	Valid Values
SP54	MSP Code A, B or G has an Effective date that is in conflict with the calculated age 65 date of the Bene.	For MSP Code A, the Effective date must not be less than the date at age 65. For MSP Code G, the Effective date must not be greater than the date at age 65.
SP55	MSP Effective date is less than the earliest Bene Part A or Part B Entitlement Date.	
SP56	MSP Prepaid Health Plan Date must be = to or greater than MSP Effective date or less than MSP Term. date.	
SP57	Termination Date Greater than 6 months prior to date added for Contractor numbers other than "11100 - 11114", 33333, 55555, 77777, 88888 or 99999.	
SP58	Invalid Insurer type, MSP code, and validity indicator combination.	If MSP code is equal to "A" or "B" or "G" and validity indicator is equal to "I" or "Y" then insurer type must not be equal to spaces.
SP59	Invalid Insurer type, and validity indicator combination	If validity indicator is equal to "N" then insurer type must be equal to spaces.
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 aux record is not equal to "J" or "K".	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
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".	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP62	Incoming term date is less than MSP Effective date.	

Error Code	Definition	Valid Values
SP66	MSP Effective date is greater than the Effective date on matching occurrence on auxiliary file	
SP67	Incoming term date is less than posted term date for Provident	
SP72	Invalid Transaction attempted	A HUSP add transaction is received from a FI or Carrier (non-COBC) with a validity indicator other than "I".
SP73	Invalid Term Date/Delete Transaction	A FI or Carrier attempts to change a Term Date on a MSP Auxiliary record with a "I" or "Y" Validity Indicator that is already terminated, or trying to add Term Date to "N" record.
SP74	Invalid cannot update "I" record.	A FI or Carrier submits a HUSP transaction to update/change an "I" record or to add an "I" record and a match MSP Auxiliary occurrence exists with a "I" validity indicator.
SP75	Invalid transaction, no Medicare Part A benefits	A HUSP transaction to add a record with a Validity Indicator equal to "I" (from an FI/carrier) or "Y" (from COBC) with an MSP Type equal to "A", "B", "C" or "G" and the effective date of the transaction is not within a current or prior Medicare Part A entitlement period, or the transaction is greater than the termination date of a Medicare entitlement period.

30.3.1 - Valid Remarks Codes
(Rev. 1, 10-01-03)

Remark Code	Definition
01	Beneficiary retired as of termination date.

Remark Code	Definition
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 that has elected the working aged exception.
08	Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan that 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 that has elected the working aged exception.
25	Spouse's employer has less than 20 employees and is multiple or multi-employer plan that has not elected the working aged exception.
26	Beneficiary's spouse is self-employed
30	Exhausted benefits under the plan
31	Preexisting condition exclusions exist
32	Conditional payment criteria met

Remark Code	Definition
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
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

Remark Code	Definition
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

30.3.2 - Valid Insurance Type Codes

(Rev. 1, 10-01-03)

Insurer Type Code	Definition
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.
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 that covers only Inpatient hospital services.
K	Medical Services Only Plan - A plan that covers only noninpatient

Insurer Type Code	Definition
	medical services.
M	Medicare Supplemental Plan, Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan.
SPACES	Unknown

30.3.3 - Other Effective Date and Termination Date Coverage Edits
(Rev. 1, 10-01-03)

If MSP Code:	Effective Date Must Be Greater Than
A - Working Aged	January 1, 1983 (830101)
A - Working Aged	Calculated Date beneficiary turned 65 (first day of month).
B - ESRD	October 1,1981
D - No Fault	December 1, 1980
E - Workers' Compensation	July 1, 1966
F - Federal/Public Health	July 1, 1966
H - Black Lung	July 1, 1973
I - Veterans' Administration	July 1, 1966
G - Disabled (43)	January 1, 1987
G - Disabled	Prior to the first day of the month the Beneficiary turns 65.
L - Liability	December 1, 1980

Other Termination date coverage edits are:

- If contractor number is that of the IRS/SSA/CMS data match project ("77777"), the term date may be equal to or greater than the effective date,
- Cannot be greater than the current date plus six months, except for MSP code = B, and

- Cannot be greater than the first day the beneficiary turned 65 if the MSP code is B or G.

30.3.4 - Employee Information Data Code
(Rev. 1, 10-01-03)

Employee Information Data Code	Valid Values
P	Patient
S	Spouse
M	Mother
F	Father

30.4 - Automatic Notice of Change to MSP Auxiliary File
(Rev. 8, 2-6-04)

The Common Working File (CWF) sends MSP transactions to all contractors of record when an MSP auxiliary record is created or changed for any beneficiary. The CWF sends this electronic transaction, known as a HUSC transaction, daily to the appropriate contractors' standard system. All contractors shall update their internal MSP files with HUSC transactions automatically. After the internal MSP files have been updated automatically, the contractor's MSP staff shall follow their current instructions regarding MSP recovery activities. This includes (1) initiating claims history searches within existing post-pay guidelines using HUSC transaction information and (2) initiating recovery actions on potential mistaken payments when appropriate.

Alerts are sent to Medicare contractors when an update is made to an MSP record. Medicare contractors shall continue to receive Unsolicited Response (UR) alerts. Although, COBC is not required to receive UR alerts for updates that were made to COBC contractor numbers (e.g., 111XX contractor numbers) as COBC receives a disposition that informs COBC that the transaction was accepted. Processing UR alerts initiated by COBC adds duplication to COBC's database and requires excess processing. The CWF is no longer required to transmit UR alerts to COBC for updates that were made to contractor number 111XX.

40 - MSP Claim Processing
(Rev. 1, 10-01-03)

The CWF performs consistency edit checks on claims submitted to it. Refer to CWF Systems Documentation for the complete record layout and field descriptions. Record names are:

- CWF Part B Claim Record, and

- CWF Inpatient/SNF Bill Record.

The MSP claims failing the consistency edits receive a reject with the appropriate disposition code, reject code, and MSP trailer data. Refer to CWF Systems Documentation, Record Name: CWF, MSP Basic Reply Trailer Data for the complete record layout and field descriptions. Claims passing the consistency edit process are reviewed for utilization compliance. Claims rejected by the utilization review process are rejected with the appropriate disposition code, reject code and MSP trailer data.

40.1 - CWF, MSP Claim Validation
(Rev. 1, 10-01-03)

There are four conditions that may occur when a contractor validates claims against the CWF, MSP auxiliary file:

- MSP is indicated on the claim and there is matching data on the CWF, MSP auxiliary record. The claim is accepted and all CWF, MSP auxiliary occurrences are returned,

- MSP is indicated on the claim and there is no matching data on an MSP auxiliary record. The claim is rejected and all CWF, MSP occurrences that apply are returned. Section 40.8 describes the CWF, MSP Utilization Error Codes, and the appropriate resolution for those codes,

- MSP is not indicated on the claim and the MSP auxiliary file has an occurrence that indicates there is MSP involvement for the time period affected. The claim is rejected and all occurrences that apply are returned, and

- MSP is not indicated on the claim and there are no matching occurrences on the CWF, MSP auxiliary file that indicate MSP involvement. The claim is accepted for payment.

NOTE: An occurrence applies if the claim service dates are equal to, or greater than, the effective date of the occurrence and less than, or equal to, the termination date of that occurrence, if there is a termination date.

40.2 - CWF Claim Matching Criteria Against MSP Records
(Rev. 1, 10-01-03)

The matching criteria between the claim and the MSP auxiliary occurrence is as follows:

- MSP types are equal;

- MSP auxiliary record validity indicator equals "Y";

- Overlapping dates of service on the claim (claim service dates after MSP effective date and before MSP termination date, if present); and

- No MSP override code used when submitting the claim.

40.3 - Conditional Payment
(Rev. 1, 10-01-03)

To make a conditional payment, FIs and carriers indicate conditional payment on the CWF, Part B Claim by placing a "C" in the "MSP code" field (field 97 of the CWF Part B Claim record.). Intermediaries indicate conditional payment on the CWF Inpatient/SNF Bill by placing zeros (0) in the **"value amount" field (position 77b)** along with the appropriate "value code". An MSP auxiliary record for the beneficiary with a "Y" validity indicator must be present. The CWF will reject the claim with error code 6805 when a claim for conditional payment is submitted and there is no matching MSP auxiliary record present.

40.4 - Override Codes
(Rev. 1, 10-01-03)

The CWF will accept MSP override codes. FIs and carriers must place the appropriate override code in the "MSP code" field (field 97) of the CWF Part B Claim record. Intermediaries must place the appropriate override code in the CWF (Inpatient/SNF Bill or Outpatient/Home Health/Hospice), "Special Action Code/Override Code, field 90". Override codes must be used only as described below.

The CWF employs the following matching criteria for override codes "M" and "N":

- Dates of service on the claim fall within the effective and termination dates on auxiliary record; and

- Validity indicator is equal to "Y".

The correct use of override codes is as follows:

A. Override code "M" is used where EGHP, LGHP and ESRD services are involved and the service provided is either:

- Not a covered service under the primary payer's plan;

- Not a covered diagnosis under the primary payer's plan; or

- Benefits have been exhausted under the primary payer's plan.

B. Override code "N" is used where non-EGHP (auto medical, no-fault, liability, Black Lung, Veterans Affairs and workers' compensation) services are involved and the service is either:

- Not a covered service under the primary payer's plan;
- Not a covered diagnosis under the primary payer's plan; or
- Benefits have been exhausted under the primary payer's plan.

Contractors receive error code 6806 when the MSP override code equals "M" or "N" and no MSP record is found with overlapping dates of service. The "Y" and "Z" override codes valid prior to the conversion of MSP data into CWF on December 10, 1990, are obsolete.

40.5 - MSP Cost Avoided Claims
(Rev. 1, 10-01-03)

Contractors shall follow the instructions cited in Chapter 5, §§50, for counting savings on MSP cost avoided claims.

They shall submit ALL MSP cost avoided claims to CWF.

Payment/Denial codes are used to identify the reason a claim was denied. Specific codes for MSP are listed and defined in §10.2 **under the MSP/COB/Contractor Number chart in that section.** Carriers submit the appropriate code to CWF in the "HUBC" claim record in field 63 "Payment/Denial Code" for line item denials. They complete the appropriate code for full claim denials in the "HUBC" claim record, field 16 "Payment/Denial". Intermediaries submit the appropriate code in the HUIP CWF record field 58 "Nonpayment" code for inpatient hospital and SNF claim denials. They submit the appropriate code in field 59 "No Pay Code" of the CWF record for the specific type of claim identified in the chart below.

PAYMENT/DENIAL CODE FIELDS IN CWF CLAIM RECORD

Contractor	Type of Claim	CWF Record	Field
Carrier	Full Claim Denial	HUBC	16 Payment/Denial
Carrier	Full Line Item Denial	HUBC	63 Payment/Denial Code
Intermediary	Inpatient hospital and inpatient SNF Denial	HUIP	58 Nonpayment Code
Intermediary	Outpatient	HUOP	59 No Pay Code
RHHI	Home Health	HUHH	59 No Pay Code

Contractor	Type of Claim	CWF Record	Field
RHHI	Hospice	HUHC	59 No Pay Code

Contractor number 88888 identifies Voluntary Data Sharing Agreements with other insurers. The denial indicator of "Q" for cost avoided claims is to be used for claims that match against the 88888 contractor auxiliary record. If the denial indicator is incorrect, the CWF software will correct the denial indicator based on the matching MSP auxiliary record and send the correct value back to the contractor on the response record header.

- It is not necessary for an MSP auxiliary record to be present in order to post MSP cost avoided savings. If one is present, the FI or carrier uses the "X" or "Y" override code as appropriate.

40.6 - Online Inquiry to MSP Data
(Rev. 1, 10-01-03)

The MSP data may be viewed online in CWF via the HIMR access. The user enters the transaction HIMR, which displays the HIMR Main Menu, and enters the MSPA selection. (A complete record layout and field descriptions can be found in the CWF Systems Documentation at http://cms.csc.com/cwf/, Record Name: MSP Auxiliary File and MSP Audit History File.)

A user can view a selected CWF, MSP auxiliary record by following the steps outlined below:

A. Enter the HICN and MSP record type.

If the data entered is invalid, an error message is displayed with the field in error highlighted. If the data entries are valid, a search is done of the beneficiary master file for an MSP indicator. The search of the master file will show one of the following:

- The MSP indicator on the beneficiary file is not set. In this case the message "MSP not indicated" is displayed;

- No record is found. In this case, a message "MSP auxiliary file not found" is displayed; or

- MSP **is** indicated. In this case, the MSP auxiliary file is read and the screen will display an MSP Record.

A successful reading of the MSP file, as noted in the third bullet above, will display an MSP occurrence summary screen that includes:

- Summary selection number;
- MSP code;
- MSP code description;
- Validity indicator;
- Delete indicator;
- Effective date; and
- Termination date, if applicable.

B. Enter the summary selection number on the MSP occurrence summary screen.

This results in a display of the MSP occurrence detail screen for the selected MSP occurrence. The MSP occurrence detail screen is a full display of the information on the MSP auxiliary file for the particular MSP occurrence.

40.7 - MSP Purge Process
(Rev. 1, 10-01-03)

The CWF process includes an MSP purge process. The CMS will determine when the purge process will be employed. The criteria for deletion of MSP data from the MSP auxiliary file will be a predetermined number of years from the following dates:

- Date of death;
- Termination date and last maintenance date; or
- Last maintenance date and delete indicator equal to "D".

The MSP purge criteria will be parameter driven. All occurrences of MSP data for a beneficiary will be copied to the MSP history audit file, and the MSP indicator on the beneficiary file will be disengaged (turned off) if no other occurrences are present on the file.

A Summary report, by originating contractor identification number, will contain the total number of MSP records affected by the purge and the total of each type of MSP occurrence deleted from the MSP auxiliary file.

40.8 - MSP Utilization Edits and Resolution for Claims Submitted to CWF
(Rev. 1, 10-01-03)

Exhibit 2, AB-00-36

Error codes 6801 - 6806 do not apply to first claim development.

Error Code	Error Description	Resolution
6801	MSP indicated on claim - no MSP auxiliary record exists on CWF data base.	Prepare an "I" MSP maintenance transaction and resubmit claim to CWF. See §10.1 for criteria to submit "I". If "I" criteria is not met, submit an MSP inquiry via ECRS.
6802	MSP indicated on claim - no match on MSP auxiliary file.	(1) Analyze CWF auxiliary file. (2) Create a new "I" MSP auxiliary record, or if "I" record criteria is not met, submit an MSP inquiry or CWF assistance request via ECRS; and (3) Resubmit claim.

NOTE: Match criteria: MSP types are equal, validity indicator equals "Y", dates of service are within MSP period and NO override code is indicated on claim.

6803	MSP auxiliary record exists - no MSP indicated on claim but dates of service match.	(1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If you have documentation showing termination of the insurance coverage indicated in the CWF, MSP occurrence, process as follows: (2) Post a termination date; or. (3) Resubmit claim as MSP. If the termination date is incorrect, submit a CWF assistance request via ECRS.
6805	MSP conditional payment claim and	(1) Create an "I" MSP Auxiliary

Error Code	Error Description	Resolution
	matching MSP record with "Y" validity indicator not found.	Record when it fits the criteria for adding an "I" record. (2) Submit MSP inquiry or CWF assistance request via ECRS. (3) Resubmit claim.
6806	MSP override code equals "M" or "N" and no MSP record found with overlapping dates of service.	If record was deleted in error, request CWF assistance request. Do not recreate record with "I" validity indicator.
6810	Part A claim was processed and only a Part B (Insurer type = "K") matching record was found.	
6811	Part B claim was processed and only a Part A (Insurer type = "J") matching record was found.	

See discussion in §40.4 above for proper use of override codes.

40.9 - CWF MSP Reject for A Beneficiary Entitled to Medicare Part B Only and A GHP

(Rev. 1, 10-01-03)

An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF will edit to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. Currently, if a contractor submits an Electronic Correspondence Referral System (ECRS) transaction to the coordination of benefits (COB) contractor to add a GHP MSP record where there is no Part A entitlement, the contractor will receive a reason code of 61. The COB contractor's system cannot delete these types of records once the records are posted to CWF by a contractor. Beginning April 2002 CWF will create a utility to retroactively delete all MSP GHP records where there is no Part A entitlement.

Contractors should not submit an ECRS request to COB to establish a GHP MSP record when there is no Part A entitlement. Contractors that attempt to establish an “I” record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A entitlement when non-employer GHP situations exists, such as automobile, liability, and workers’ compensation. Where a non-employer GHP situation exists, the contractor should continue to submit ECRS transactions and establish “I” records, as necessary.

50 - Special CWF Processes
(Rev. 1, 10-01-03)

50.1 - Extension of MSP-ESRD Coordination Period
(Rev. 1, 10-01-03)

Section 4631(b) of the Balanced Budget Act (BBA) of 1997 permanently extends the coordination period to 30 months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed an 18-month coordination period by July 31, 1997, will have a 30-month coordination period under the new law. The Common Working File (CWF) will deny claims for primary payment that are submitted for applicable individuals during the 30-month coordination period. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

A one-time utility program was executed in CWF to extend the ESRD coordination period for applicable individuals (those records with a Medicare Secondary Payer (MSP) code of "B" and a coordination period termination date of August 1997, or later) to 30 months. This was done by adding 12 months to all coordination periods with a termination date on or after August 1997. All applicable records were changed by September 1, 1997. Any open records (those which do not have a termination date) remained open until they closed using the existing mechanisms, but following the time guidelines outlined above. That is, any ESRD, MSP termination dates, which were added to CWF where the coordination period ended in August 1997 or later, now reflect the new 30-month period. Claims erroneously submitted for primary payment are rejected with CWF Utilization Error Code 6803.

50.2 - Sending of HUSC Files From CWF to Recovery Management and Account Systems (ReMAS)
(Rev. 1, 10-01-03)

A. Background of ReMas

Recovery Management and Account Systems (ReMAS) is a system that will identify mistaken Medicare primary payments in the case where Medicare should have paid secondary. In some instances, other insurance is available to pay for furnished services and Medicare payment is secondary to the payment obligation of the other insurance. Medicare does not generally make a primary payment if it should be the secondary payer, and it is aware that the insurance obligated to pay before Medicare is available. If Medicare makes a mistaken primary payment in such a situation, Medicare pursues recovery of the mistaken primary payment from an appropriate party. ReMAS will identify these mistaken payments so that recovery can be initiated from the party that should have paid primary. ReMAS replaces several contractor systems, as well as CMS systems in order to integrate the identification of mistaken MSP overpayments into a

centralized database. ReMAS depends on an interface with CWF to receive notification of beneficiaries that had insurance coverage primary to Medicare. A separate, future instruction will explain how and when Medicare Contractors will use ReMAS.

B. Purpose, Frequency and File Description of CWF Interface with ReMAS
In order for ReMAS to receive notice of MSP situations, it will receive HUSC records from each CWF host on a daily basis. All CWF hosts will transmit HUSC records to ReMAS for every HUSP record that is accepted in CWF. The CWF will send these records to ReMAS using contractor number 11200. All files from each CWF host are sent to the CMS Data Center through the CMS mainframe telecommunication information system (MTIS) process, to a specific data set name that will be provided.

C. Data Feeds

Initial Data Feed: ReMAS will provide an Initial Data Feed Date to CWF. CWF will send any MSP occurrence (MSP Type Values "A"= Working aged; "B"= ESRD; "D"= Automobile Insurance, No-Fault; "E"= Workers' Compensation; "G"= Disabled; "L"= Liability) that was added to CWF since the Initial Data Feed Date.

Ongoing Data Feeds: CWF will send any valid new MSP occurrence (MSP Type A, B, D, E, G, or L). CWF will send any updates to any valid MSP occurrence (MSP Type A, B, D, E, G, or L). CWF will send any deletes of any valid MSP occurrences (MSP Type A, B, D, E, G, or L).

60 – Use of Inter-Contractor Notices (ICNs) and CWF for Development Conditional Payment Amount

(Rev. 1, 10-01-03)

As a result of the implementation of the Coordination of Benefits Contractor (COBC), lead recovery contractor identification and notification will be done by the COBC; the lead recovery contractor continues to be responsible for the identification and recovery of Medicare's MSP claim. Medicare manual sections cited in the Budget Performance Requirements (BPRs) address the responsibilities of the lead contractor.

The CMS has designated fiscal intermediaries as the leads for all new liability, no-fault, workers' compensation, and FTCA recoveries. Carriers retain the lead for any pre-existing pending cases for which they were the lead recovery contractor prior to the implementation of the COBC.

Prior instructions called for lead recovery contractors to issue ICN requests to all contractors having paid claims related to an identified liability, no-fault, workers' compensation, or FTCA case. The ICN requests are for purposes of developing the conditional payment amount associated with any claims paid by another contractor. Effective October 1, 2002, contractors began to utilize CWF to identify related conditional payments in certain situations.

60.1 – General Rules for the Use of ICNs vs CWF for Development of Medicare's Conditional Payment Amount
(Rev. 1, 10-01-03)

When the date of the accident/injury/illness/incident is within 18 months of the contractor's notification of lead recovery contractor status via COBC, contractors must develop the total conditional payment amount through the use of CWF, rather than ICNs. Where the initial conditional payment amount was obtained through the use of ICNs; but the notice of settlement, judgment, or award is less than 22 months from the date the initial conditional payment amount was furnished, the lead recovery contractor will obtain updated amounts through the use of CWF. Where workload permits, the lead recovery contractor should update the conditional payment amounts near the end of the expiration of the 22-month period in order to avoid the need for an ICN at the time of settlement, judgment, or award. When obtaining claims information from the CWF, the lead recovery contractor must retrieve archived claims via the appropriate command (i.e., MSPA, MSPB, INPL, OUTL). If the data is purged and the lead recovery contractor has the ability to retrieve it, they must do so. Contractors have been furnished with OSCAR access (for institutional provider information), the UPIN directory disc (for physician, nurse practitioner, clinical nurse specialists, and physician assistant information), and with a process to gain access to the National Supplier Clearinghouse (NSC) (for DMEPOS supplier information).

Where the date of accident/injury/illness/incident in comparison to the lead notification via COBC is greater than 18 months, the lead recovery contractor will send ICNs to the non-lead contractors. Non-leads must respond to the ICN request within 45 days from receipt, except in response to a notice of settlement, judgment, or award. Non-lead contractors have 30 days to respond to a notice of settlement, judgment, or award ICN if they had no prior ICN request; and 15 days to respond if the ICN request is a request to update the conditional payment amount previously received. Where the time span between the development of the initial conditional payment amount and notification of a settlement, judgment, or award exceeds 22 months, the lead recovery contractor may develop the updated conditional payment amount by ICN.

All contractors should be aware that because product liability situations are often unknown for some time after the product at issue is first used, many product liability situations are likely to exceed the 18-month time frame for initial notification and will require the use of ICN requests to develop Medicare's conditional payment amounts.

NOTE: The retention period for CWF claims data has been increased to a minimum of 24 months. This change, in conjunction with the rules stated above, will allow lead recovery contractors to deal with occasional backlog situations. Even where the initial notification of an accident/injury/illness/incident is near the end of the 18-month period, contractors will have adequate time to develop the conditional payment amount without the need for ICNs.

A. ICN Requests By The Lead Recovery Contractor When the 18-Month Period Has Not Expired

Non-lead contractors do not need to respond to ICN requests sent within the 18-month period. They should annotate such ICNs with the reason the ICN is not being processed and immediately return the ICN to the lead contractor (to ensure that the lead contractor can obtain the information from CWF while it is still available). If a non-lead contractor experiences repeated problems with this issue from a particular lead contractor, they should notify their regional office (RO).

ICN Backlog Issues

If an ICN backlog (for issuing and/or replying to ICN requests) develops, contractors are required to report the situation to their RO MSP Coordinator immediately, provide a plan for elimination of the backlog, and obtain RO approval of the plan. The plan for eliminating an ICN backlog must involve simultaneously working both new and old lead assignments in order to minimize the number of ICNs that must be issued. Non-lead contractors must respond to ICN requests where the 24-month CWF minimum period for claims data retention has expired even if they believe that the issuing contractor should have been able to obtain the information from the CWF before the 24-month period expired. If a receiving contractor is concerned about repeated situations with a particular contractor, it must notify its RO. The RO will ascertain whether the other contractor at issue is in the midst of eliminating a backlog.

ICN Request Content Issues

ICN requests must always provide sufficient information for the non-lead contractor to readily identify if an incoming ICN is an initial request or a follow-up request and whether or not a settlement, judgment, or award has occurred (including the date). ICN requests should also be clearly marked to show that no CWF record exists, in those limited circumstances where a contractor has been directed not to establish a CWF record.

Contractors are reminded that ICN requests must include a narrative description of the accident/injury/illness/incident and/or related diagnosis codes as well as the date of the accident/injury/illness/incident.

ICN Responses

Non-lead contractors responding to ICN requests are reminded that ICN responses must specifically annotate/identify all related claims; the non-lead contractor may not simply furnish a “history dump” without further identification of those claims which are related to the accident/injury/illness/incident. Non lead contractors are reminded that they must also furnish appropriate claims detail; they may not simply furnish a dollar total for related claims.

Reminder Regarding Termination Updates to the CWF

When the lead recovery contractor is notified, by writing or via telephone conversation of a settlement, judgment, or award, the date of that settlement, judgment or award should be entered in the termination field of the CWF immediately. The lead recovery contractor must **not** delay entry of the termination date until the recovery demand letter is issued or until the debt is repaid and the case is closed. Failure to perform a timely update puts the Medicare trust funds at risk.

Reminder Regarding Savings Information to Non-Lead Contractors

The lead recovery contractor continues to be responsible for reporting appropriate savings amounts to non-lead contractors even where conditional payment amounts were developed using CWF. The lead recovery contractor must furnish sufficient detail with this notification for the non-lead to report appropriate savings and process any necessary claim adjustments. If there is a beneficiary specific recovery in a situation where CMS has determined that a CWF MSP record is not appropriate, all savings should be reported by the lead contractor without any claim adjustments.

70 - Converting Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Codes to Common Working File (CWF) Medicare Secondary Payer (MSP) Patient Relationship Codes

(Rev 12, 03-05-04)

CMS has realized that its Common Working File (CWF) HUSP transaction does not allow for the correct association of HIPAA individual relationship codes, as found in the HIPAA 837 (version 4010) Institutional and Professional Claims Implementation Guides, with corresponding MSP Type Codes, such as working aged (A), end-stage renal disease (B), and disability (G). Therefore, effective July 6, 2004, all intermediaries that receive incoming electronic HIPAA, DDE, or hard copy claims that are in the HIPAA ANSI X-12 format shall convert the incoming individual relationship codes to their equivalent CWF patient relationship codes. Until further notice, intermediaries shall continue to operate under the working assumption that all providers will be including HIPAA individual relationship codes on incoming claims.

Before CMS' systems changes are effectuated, intermediaries may receive SP edits (i.e., SP-33 and SP-52) that indicate that an invalid patient relationship code was applied. Intermediaries are to resolve those edits by manually converting the HIPAA individual relationship code to the CWF patient relationship code, as specified in the conversion chart below. If the intermediary receives MSP edits and can determine that the HIPAA individual relationship code rather than the CWF patient relationship code was submitted on the incoming claim, it shall manually work the MSP edits incurred by converting the HIPAA individual relationship code to the appropriate CWF patient relationship code.

Until Part A shared system changes are effectuated to convert HIPAA individual relationship codes to CWF patient relationship codes, intermediaries may move claims

with a systems age of 30 days or older that have suspended for resolution of patient relationship code, including SP-33 or SP-52 edits, to condition code 15 (CC-15).

The Part A contractor system shall utilize the conversion chart, found below, to cross-walk incoming HIPAA individual relationship codes to the CWF patient relationship code values.

HIPAA Individual Relationship Codes	**Convert To CWF Patient Relationship Codes**	**Valid Values**
18	01	Patient is Insured
01	02	Spouse
19	03	Natural Child, Insured has financial responsibility
43	04	Natural Child, insured does not have financial responsibility
17	05	Step Child
10	06	Foster Child
15	07	Ward of the Court
20	08	Employee
21	09	Unknown
22	10	Handicapped Dependent
39	11	Organ donor
40	12	Cadaver donor
05	13	Grandchild
07	14	Niece/Nephew
41	15	Injured Plaintiff
23	16	Sponsored Dependent
24	17	Minor Dependent of a Minor Dependent

32,33	18	Parent
04	19	Grandparent
53	20	Life Partner
29	N/A	Significant Other
30	N/A	?
31	N/A	?
36	N/A	?
G8	N/A	?
Other HIPAA Individual Relationship Codes	N/A	?

Intermediaries shall allow for the storing of CWF patient relationship codes in their internal MSP control files, since these files should be populated with information sent back to the intermediaries' systems via the automated HUSC transaction.