CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13168	**Date: April 16, 2025**
	Change Request 13591

Transmittal 13070 issued March 20, 2025, is being rescinded and replaced by Transmittal 13168, dated April 16, 2025, to add Business Requirement (BR) 13591.15 and to revise BRs 13591.5.1, 13591.5.2, 13591.5.3 and 13591.5.4. All other information remains the same.

SUBJECT: Updates to the Medicare Carrier System (MCS), the Viable Information Processing Systems Medicare Systems (VMS) and the Common Working File (CWF) Processes to Capture and Further Automate the Medicare Secondary Payer (MSP) Processes

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to establish functionality in MCS to apply the CWF MSP information to the claim at a detail level and ensure the CWF MSP information used to adjudicate the claim detail is not altered in MCS history. This CR establishes functionality in MCS and VMS to further automate the MSP cost avoid process to consider the prompt pay period for non-ongoing responsibilities for medicals (ORM) MSP Types 14, 15 and 47 prior to dispositioning the claim and establishes functionality in CWF to apply MSP editing and override processing at the detail level allowing services not applicable to the MSP processing to remain on the claim, such as Flu codes or services, that are outside the MSP period.

EFFECTIVE DATE: January 1, 2025 - Requirements, Design, and Coding (CWF and MCS); April 1, 2025 - Requirements, Design & Coding, Testing, for claims processed on or after this date, and Implementation (CWF, MCS, and VMS)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025 - Requirements, Design, and Coding (CWF and MCS); April 7, 2025 - Requirements, Design & Coding, Testing, and Implementation (CWF, MCS, and VMS)

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	6/40/MSP Claim Processing

III. FUNDING:

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

Attachment - Business Requirements

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to establish functionality in MCS to apply the CWF MSP information to the claim at a detail level and ensure the CWF MSP information used to adjudicate the claim detail is not altered in MCS history. This CR establishes functionality in MCS and VMS to further automate the MSP cost avoid process to consider the prompt pay period for non-ongoing responsibilities for medicals (ORM) MSP Types 14, 15 and 47 prior to dispositioning the claim and establishes functionality in CWF to apply MSP editing and override processing at the detail level allowing services not applicable to the MSP processing to remain on the claim, such as Flu codes or services, that are outside the MSP period.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to establish systematic functionality at CWF and MCS to apply the CWF MSP information to the claim at a detail level and ensure the CWF MSP information used to adjudicate the claim detail is not altered in MCS history. It is the systems goal to establish functionality in MCS and VMS to further automate MSP cost avoid processing to consider the prompt pay period for non-ORM MSP Types 14, 15 and 47 prior to processing the claim. This update will also allow CWF to apply MSP editing and override processing at the Part B detail level allowing services, not applicable to the MSP processing, to remain on the claim when the services that are outside of the MSP period.

B. Policy: The MSP policy allows for Medicare to pay claims as a secondary payer when another insurer is primary to Medicare. CMS has been working with the shared systems to improve the processing of MSP claims systematically. Through recent discussions on the MSP Functional Work Group (FWG) calls, CMS, DME and the Part B shared system, along with the Part B and DME MACs, identified areas of MSP processes that can be handled systematically with limited manual intervention. Updating the Part B system and CWF will allow for claims to process more systematically for the following:

- Allow claims to consider the Prompt Pay Period for non-ORM MSP Types No-Fault (14), Workers Compensation (15) and Liability (47) prior to processing the claim,
- Prevent receipt of the CWF 03 Trailer with Disposition 01 from overlaying the information used to process the claim in MCS,
- Prevent delays in processing MSP claims due to conflicts between claim and detail level processing,

- Prevent delays in processing MSP claims due to addition and/or removal of the MSP information from the MCS claim
- Prevent manual processing of MSP claims due to the Informational MSP update being rejected by CWF, and
- Updates to the DME MACs and VMS shared system

MSP policy, processing and procedures will remain the same and will continue to follow all MSP Laws and Regulations when these updates are implemented.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13591.1	BDS and CWF shall accept MSP Error overrides at the details for Part B claims for the following error codes: 6802, 6803, 6815, 6816, 6817, 6818, 6819, 6820, 6823, 6824, 6832, 6833, 6836, and 6837. Note, MSP information will be identified on trailers 03 08 and 39.		X		X				X	
13591.2	BDS/CWF shall update the 39 Trailer to specifically identify the diagnosis codes on the claim that are matching, based on existing CWF error rules, on the returned MSP record. Note, Trailer 39 shall contain the 2 new fields for each line on the trailer. • 1 byte field for the diagnosis qualifier, and • 7 byte field for the diagnosis code. .						X	X	X	
13591.2.1	MCS and VMS shall accept the modified CWF 39 trailer.						X	X		
13591.2.2	MCS and VMS shall update the screens that display the						X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	modified CWF 39 trailer.									
13591.2.3	MCS shall update the response generator to include the additional fields on the BDS/CWF Trailer 39.						X			
13591.3	MCS shall modify the auto creation and update of the MCS MSP claim specific internal record (M Trailer) when the BDS/CWF 03 Trailer is received for adjudication. Note, the 'M' Trailer is internal to MCS and stores the MSP information sent by BDS/CWF in the 03 Trailer. This internal trailer is used to process the claim.						X			
13591.3.1	MCS shall map the BDS/CWF 03 Trailer to the MCS M (MSP) Claim Trailer when BDS/CWF returns any disposition other than an acceptance record (disposition 01).						X			
13591.3.2	MCS shall map the CWF 03 Trailer to the MCS M (MSP) Claim Trailer when BDS/CWF returns an acceptance record and the claim does not have an MCS M Claim Trailer, otherwise do not map the BDS/CWF 03 Trailer to the claim.						X			
13591.4	Part B MACs shall reject claims when the BDS/CWF Error 6802 is received. Note, no savings should be taken on the claim.		X							
13591.4.1	BDS/CWF shall return trailers 03 and 39 for BDS/CWF Error 6802.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13591.4.2	MACs shall use Claim Adjustment Reason Code (CARC) 16, Claim/service lacks information or has submission/billing error(s), with Group Code (GC) 'CO,' Contractual Obligation, to return the claim: Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Part B MACs shall use RARC N245, Incomplete/invalid plan information for other insurance.		X							
13591.5	BDS/CWF shall update the existing CWF Error 6819 and 6833 to fail when the ORM indicator is not present and create new errors that fail when the ORM indicator is present.		X		X			X	X	
13591.5.1	BDS/CWF shall update Error '6819' for Prompt Payment when the ORM (Ongoing Responsibility for Medicals) indicator is not present, under the following conditions: • For Auto No-Fault (MSP Type 'D'): The Date of Service (DOS) is more than		X		X			X	X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	120 days before the Claim Receipt Date. • For Workers' Comp (MSP Type 'E'): The Date of Service (DOS) is more than 120 days before the Claim Receipt Date. • For Liability (MSP Type 'L'): The DOS is more than 120 days after the MSP Auxiliary File Accretion Date. **Additional details:** • The error is triggered based on the diagnosis in the claim detail line only. • The incoming HUBC/HUDC record does not contain any MSP Type ('D', 'E', 'L') non-GHP MSP. • The diagnosis on the incoming claim matches the diagnosis within the family of diagnosis codes in the MSP Type ('D' or 'L') non-GHP MSP occurrence on the MSP auxiliary file. • The diagnosis on the incoming claim is an exact match or the diagnosis matches a diagnosis within the family of diagnosis codes for an MSP Type 'E' non-GHP									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MSP occurrence on the MSP auxiliary file. • The ORM indicator is absent. **NOTE**: MSP Type 'H' shall be removed from '6819' logic.									
13591.5.1.1	**Outside 120 days, Part B and DME MACs shall use the following Conditional Payment informational message**: • Remark M32 - Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service. • Remark N4 - Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.		X		X					
13591.5.2	BDS/CWF shall create a new error ('6839'), similar to Error		X		X			X	X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	'6819' for Prompt Payment, when the ORM (Ongoing Responsibility for Medicals) indicator is not present and the following conditions apply: • For Auto No-Fault (MSP Type 'D'): The Date of Service (DOS) is less than or equal to 120 days before the Claim Receipt Date. • For Workers' Comp (MSP Type 'E'): The Date of Service (DOS) is less than or equal to 120 days before the Claim Receipt Date. • For Liability (MSP Type 'L'): The DOS is less than or equal to 120 days after the MSP Auxiliary File Accretion Date. Additional details: • The error is triggered based on the diagnosis in the claim detail line only. • The incoming HUBC/HUDC record does not contain any MSP Type ('D', 'E', or 'L') non-GHP MSP. • The diagnosis on the incoming claim matches the diagnosis within the family of diagnosis codes in the									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MSP Type ('D' or 'L') non-GHP MSP occurrence on the MSP auxiliary file. • The diagnosis on the incoming claim is an exact match or the diagnosis matches a diagnosis within the family of diagnosis codes for an MSP Type 'E' non-GHP MSP occurrence on the MSP auxiliary file. • The ORM indicator is absent. **NOTE**: MSP Type 'H' will be removed from '6839' logic.									
13591.5.2.1	The Part B and DME MACs shall use the following denial messages (ICN RCT date minus DOS): For Auto/No Fault and the dates of service (DOS) is within the 120 day period (ICN RCT date minus DOS) • CARC 21 - This injury/illness is the liability of the no-fault carrier. • GROUP CODE - CO • RARC- MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The informatio		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	n was either not reported or was illegible. • MSN 29.11 - Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. For Worker's Compensation and dates of service within the 120 day period (ICN RCT date minus DOS): • CARC 19 - This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. • GROUP CODE - CO • RARC - MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. • MSN 29.8 - This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan.									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	For Liability and dates of service within the 120 day period (ICN RCT minus DOA or DOS): • CARC 20 - This injury/illness is covered by the liability carrier. • GROUP CODE - CO • RARC - MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. • MSN 29.11 - Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer.									
13591.5.3	BDS/CWF shall update Error '6833' when the Date of Service (DOS) is outside the Prompt Payment period, and the ORM (Ongoing Responsibility for Medicals) indicator is not present. The following conditions will apply: • For non-GHP Auto No-Fault (MSP Type 'D') and Workers'		X		X			X	X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Comp (MSP Type 'E'): The DOS is more than 120 days before the Claim Receipt Date. • For non-GHP Liability (MSP Type 'L'): The DOS is more than 120 days after the MSP Auxiliary File Accretion Date. Additional details: • The error will be triggered based on the diagnosis in the claim's detail line only. • The incoming HUBC/HUDC record does contain an MSP Type ('D', 'E', or 'L') non-GHP that matches the non-GHP on the MSP Auxiliary File. • The ORM indicator is absent. The diagnosis on the incoming claim: • If ICD-9, does not exactly match or belong to the same family as the ICD-10 diagnosis in the non-GHP MSP occurrence on the MSP Auxiliary File; or									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• If ICD-10, does not exactly match or belong to the same family as the ICD-9 diagnosis in the non-GHP MSP occurrence on the MSP Auxiliary File.									
13591.5.3.1	**Outside 120 days, Part B and DME MACs shall use the following Conditional Payment informational message**: • Remark M32 - Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service. • Remark N4 - Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.		X		X					
13591.5.4	BDS/CWF shall create a new error (‘6840’), similar to Error ‘6833’, for the following conditions: • For non-GHP Auto No-Fault (MSP Type ‘D’) or Workers'		X		X				X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Comp (MSP Type 'E'): The Date of Service (DOS) is less than or equal to 120 days before the Claim Receipt Date. • For non-GHP Liability (MSP Type 'L'): The DOS is less than or equal to 120 days after the MSP Auxiliary File Accretion Date. Additional details: • The error will be triggered based on the diagnosis in the claim's detail line. • The incoming HUBC/HUDC record does contain an MSP Type ('D', 'E', or 'L') non-GHP that matches the non-GHP on the MSP Auxiliary File. • The ORM (Ongoing Responsibility for Medicals) indicator is absent. Diagnosis matching: • If the ICD-9 diagnosis on the incoming claim does not exactly match or is not within the same family as the ICD-10 diagnosis in the non-GHP MSP record.									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• If the ICD-10 diagnosis on the incoming claim does not exactly match or is not within the same family as the ICD-9 diagnosis in the non-GHP MSP record. Note, the MACs shall deny the claim if the diagnosis is related to the non-GHP record and if the DOS is within the 120 day prompt period for non ORM situations									
13591.5.4.1	For Auto/No Fault, Liability and Workers' Compensation and the dates of service is within the 120 day period, the Part B and DME MACs shall use the following denial messages (ICN RCT date minus DOS): • CARC 21 - This injury/illness is the liability of the no-fault carrier. • GROUP CODE - CO • RARC MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. For Auto/No Fault and the dates of service (DOS) is within the 120 day period (ICN RCT date minus DOS)		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CARC 21 - This injury/illness is the liability of the no-fault carrier. • GROUP CODE - CO • RARC MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. • MSN 29.11 - Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. For Worker's Compensation and dates of service within the 120 day period (ICN RCT date minus DOS): • CARC 19 - This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. • GROUP CODE - CO • RARC - MA04 - Secondary payment cannot be considered without the identity of or payment information from the									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	primary payer. The information was either not reported or was illegible. • MSN 29.8 - This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan. For Liability and dates of service within the 120 day period (ICN RCT minus DOA or DOS): • CARC 20 - This injury/illness is covered by the liability carrier. • GROUP CODE - CO • RARC - MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. • MSN 29.11 - Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer.									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13591.5.5	BDS/CWF shall create a new BDS/CWF Error '6841,' like 6833, but the ORM indicator is present. • An incoming Part B claim (HUBC) is received that contains an ICD-9 Diagnosis code that is not an exact or family match to the ICD-10 Diagnosis code on the open non-GHP MSP Aux record ('D', 'E', 'L') and the ORM indicator is present. • An incoming Part B claim (HUBC) is received that contains an ICD-10 Diagnosis code that is not an exact or family match to the ICD-9 Diagnosis code on the open non-GHP MSP Aux record ('D', 'E', 'L) and the ORM indicator is present. • Note: BDS/CWF will utilize the detail line diagnosis codes for HUBC claim to match the family.		X		X				X	
13591.5.5.1	The Part B and DME MAC shall use the following denial messages when the ORM indicator is present for No Fault Situations: CARC 21 - This injury/illness is the liability of the no-fault carrier.		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	GROUP CODE - CO RARC N727 - This injury/illness is the liability of the no-fault carrier. A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. MSN 21.35 - This claim was denied. Your auto/no-fault insurance plan had the on-going responsibility for medicals (ORM). Your auto/no-fault insurance plan is responsible for paying this claim. For Liability and dates of service with ORM CARC 20 - This injury/illness is covered by the liability carrier. A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. GROUP CODE - CO RARC N725 - This injury/illness is covered by the liability carrier. A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. MSN 21.34 - This claim was denied. Your liability insurance plan has the on-going responsibility for medicals (ORM). Your									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	liability insurance plan is responsible for paying this claim. For Worker's Compensation and dates of service with ORM: CARC 19 - This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. GROUP CODE - CO RARC N728 - A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. MSN 21.33 - Your workers' compensation insurance plan is responsible for paying this claim.									
13591.6	CWF shall create 1 new HUSP (SP) error to fail when a record is sent to CWF for a NGHP and there is not a diagnosis code.		X						X	
13591.6.1	CWF shall create a new HUSP (SP) error to fail when a record is sent to CWF for a NGHP and there is no qualifier indicator and/or diagnosis code on the HUSP transaction.								X	
13591.6.2	MCS shall add the new HUSP (SP) error to the BDS/CWF error module utilized when validating I records to set the SP error if an NGHP I record		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	is created and a diagnosis code is not present.									
13591.7	MCS shall create a mechanism to process the claim based on the combination of the BDS/CWF Error and a HUSP error (SP) for the ICN.						X			
13591.8	MCS shall purge I records from the I record file and provide the MACs with a way to retrieve the purged I records, if needed.						X			
13591.8.1	MCS shall purge I records greater than 60 days regardless of the CWF update date on the MCS 'I' record file.						X			
13591.8.2	MCS shall display the purged 'I' Records on the IM screen or a new similar screen and MACs can request the purged record to be retrieved.		X				X			
13591.8.3	MCS shall retain the purged 'I' records for a minimum of 5 years.		X				X			
13591.9	MCS shall remove the logic to suppress I records when there is an existing record for the same MBI, MSP Type and Effective Date. Note: this will ensure a record was attempted for the QASP Audit.						X			
13591.10	MACs shall reject a NGHP MSP claim when there is not a corresponding NGHP record at BDS/CWF, and the date of accident or date of loss is not received on the claim. Note, the MAC will have this ability once MCS adds the		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	functionality.									
13591.10.1	MCS shall map the Accident date to the PX(P) record from the inbound 5010 when the accident date is received in the 2300 DTP segment and no longer map the Date of Service to the Accident Date Field on the PX(P) file.						X			
13591.10.2	MACs shall use Group Code Contractual Obligation 'CO' with CARC 16, Claim/service lacks information or has submission/billing error(s), to return the claim identified in the above requirement: Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Part B MACs shall use RARC N305 to return the claim: Missing/incomplete/invalid injury/accident date.		X							
13591.11	The identified shared systems shall perform integrated testing during the ALPHA timeframe of the implementation release.						X	X	X	
13591.12	The Part B MACs and DME MACs shall also test this change request.		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13591.13	The identified shared systems and BDS/CWF shall schedule the MSP release outside of the normal UAT time frame so the Part B MACs and DME MACs can begin testing earlier and given more time to complete testing. Part A MACs do not need to test CR13591, **Note:** The full April 2025 release will be delivered to MIST, the CWF Host for UAT Testing, and BETA on February 6th, 2025, and be available for MAC testing beginning February 10, 2025. HIGLAS will release its code on February 24, 2025.		X		X		X	X	X	HIGLAS, Hybrid Cloud Data Center (HCDC)
13591.13.1	This BR shall require early BETA software receipt for the DME MACs.				X					
13591.14	This requirement has been deleted.		X		X				X	
13591.14.1	This requirement has been deleted.		X		X					
13591.15	The BDS and CWF shall create a new Error ‘6842’ for the original functionality of ‘6833’ with only MSP Types ‘S’, ‘T’, ‘W’."		X		X				X	
13591.15.1	BDS/CWF shall create a new BDS/CWF ‘6842’. • An incoming Part B claim (HUBC) is received that contains an ICD-9 Diagnosis code that is not an exact or family match to the ICD-10 Diagnosis code on the open non-GHP MSP Aux								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	record ('S', 'T', or 'W'). • An incoming Part B claim (HUBC) is received that contains an ICD-10 Diagnosis code that is not an exact or family match to the ICD-9 Diagnosis code on the open non-GHP MSP Aux record ('S', 'T', or 'W'). Note: BDS/CWF will utilize the detail line diagnosis codes for HUBC claim to match the family.									
13591.15.2	The Part B and DME MAC shall use the following denial messages for S, T and W Set Asides Situations: For Auto/No Fault: • Group Code PR • CARC 201 - Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)		X		X				X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• RARC N724 - Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item. • MSN 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies). For Worker's Compensation: • Group Code PR • CARC 201 - Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) • RARC N722 - Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• MSN 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies). For Liability: • Group Code PR • CARC 201 - Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) • RARC N723 - Patient must use Liability set-aside (LSA) funds to pay for the medical service or item. • MSN 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	prescription drug treatment related to your injury(ies).									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part B, DME MAC

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

40 - MSP Claim Processing

(Rev. 13168; Issued: 04-16-25; Effective: 01-01-25; Implementation: 01-06-25)

The Common Working File (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 Medicare Secondary Payer (MSP) claims failing the consistency edits shall 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.

The shared systems establish their own systematic functionality to apply the CWF MSP information on the claim or at a detail level for Part B and Outpatient claims and ensure the CWF MSP information used to adjudicate the claim is not altered. It has always been the shared systems' goal to establish functionality to automate MSP cost avoid processing for group health plan claims and to consider the prompt pay period for non-ORM MSP Types 14, 15 and 47 (No-fault, Workers' Compensation and Liability, including self-insurance) prior to processing the claim. The cost avoid process also applies to ORM non-group health plan claims so that Medicare does not make a mistaken primary payment.

CWF also applies MSP editing and override processing at the claim, or detail level, allowing services not applicable to the MSP processing to remain on the claim. The goal of the shared systems is to allow for the least number of claims requiring manual review and processing. Systematic automation prevents delays in processing MSP claims such as:

- *conflicts between claim and detail level processing,*
- *addition and/or removal of the MSP information from the claim,*
- *manual processing of MSP claims due to the Informational MSP update being rejected by CWF,*
- *Resolving MSP claims errors including secondary payer and 6800 error codes, and*
- *Systematically creating MSP records.*

The Centers for Medicare & Medicaid Services (CMS) encourages the shared systems, the A/B Medicare Administrative Contractors (MACs) and Durable Medicare Equipment (DME) MACs to provide insight and recommendation to further automate the MSP claims processes. This improvement can be identified and discussed at your functional work group meetings and/or relayed through your designated CMS Contracting Officer Representative (COR) who will refer your recommendation to the appropriate CMS MSP staff.