CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12240	**Date: September 6, 2023**
	Change Request 13037

Transmittal 11833 issued February 02, 2023, is being rescinded and replaced by Transmittal 12240, dated September 6, 2023, to change the Effective and Implementation dates of the CR and to make changes to Business Requirements (BRs) 13037.2 and 13037.6 and to remove BRs 13037.3 and 13037.5. All other information remains the same.

SUBJECT: Patient Responsibility Reporting with Medicare Secondary Payer (MSP)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Multi-Carrier System (MCS) how to use CARC 23 to report prior payer adjudication in the case of a secondary claim. If the impact needs to be reported at the claim level, OA 23 should be used at the claim level. Alternatively, if the impact needs to be reported at the service line level, OA 23 should be used at the service line level (once for each service line).

EFFECTIVE DATE: July 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 9, 2023

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 12240	Date: September 6, 2023	Change Request: 13037

Transmittal 11833 issued February 02, 2023, is being rescinded and replaced by Transmittal 12240, dated September 6, 2023, to change the Effective and Implementation dates of the CR and to make changes to Business Requirements (BRs) 13037.2 and 13037.6 and to remove BRs 13037.3 and 13037.5. All other information remains the same.

SUBJECT: Patient Responsibility Reporting with Medicare Secondary Payer (MSP)

EFFECTIVE DATE: July 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 9, 2023

I. GENERAL INFORMATION

A. Background: Medicare beneficiaries may have multiple coverages. If Medicare is the secondary payer, considerations are based on the adjudication by the previous payer(s) and reflected on the Remittance Advice (RA) accordingly.

The implementation guide for the current Electronic Remittance Advice (ERA) - ASC X12 Transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration): "Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.) and Claim Adjustment Group Code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment. It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." When this happens, reporting the actual payment would prevent the transaction from balancing."

Medicare is not required to report previous payer information, as this information is reported by the previous payer to the provider via the previous payer's Remittance Advice. In order to generate and send a balanced Medicare Remittance Advice and COB Claim, Medicare should report only the part of previous payer's adjudication that impacts Medicare calculation of payment and adjustments.

B. Policy: Medicare sends HIPAA compliant transactions.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13037.1	The contractor shall report when the amount paid by Medicare is impacted by the primary payer payment, any patient responsibility for which the patient is still responsible						X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	for after the coordination of benefits with the previous payer(s) with Group Code PR and the appropriate Claim Adjustment Reason Code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount). Note: Adjustments to the Medicare paid amount as a result of the primary payer payment, including Medicare Deductible or Coinsurance shall be reported under Group Code OA and Claim Adjustment Reason Code 23. This does not apply to denied services, those should report as they do today.									
13037.2	The contractor shall report any further adjustment taken by Medicare as a result of previous payer(s) payment and/or adjustment(s) with Group Code OA and Claim Adjustment Reason Code 23 for the Standard Paper Remittance and the 835. Note: OA 23 shall be reported on the Standard Paper Remittance and the 835 only once showing the total "impact" amount at the claim level or once at each service level as appropriate.						X			
13037.3	This requirement has been deleted.						X			
13037.4	The contractor shall ensure the amount reported in the 835 CLP05 equals the sum of all claim and service line adjustments with Claim Adjustment Group Code PR.						X			
13037.5	This requirement has been deleted.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13037.6	The Contractor shall ensure for all non-assigned claims that the beneficiary is responsible for up to the provider's limiting charge amount as long as the limiting charge does not exceed the billed amount. Note: The beneficiary is responsible to pay whichever amount in lower. On a non-assigned claim the OA 23 shall contain the primary payers paid amount.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. 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

V. CONTACTS

Pre-Implementation Contact(s): Charlene Parks, 410-786-8684 or Charlene.Parks@cms.hhs.gov , Barbara Pecoraro, 410-786-6188 or Barbara.Pecoraro@cms.hhs.gov

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

VI. 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