Program Memorandum
Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-016 **Date: FEBRUARY 7, 2003**

CHANGE REQUEST 2552

SUBJECT: CR 2240 Question and Answer Document

Background

This Program Memorandum is being circulated to all contractors to respond to Medicare contractor questions received during the comment period of CR 2240, AB-02-107, dated July 31, 2002 titled "Modify Application of 'I' Validity MSP Records to the Common Working File (CWF) by Medicare Contractors."

This clarification PM does not impose any new standard systems and CWF changes.

Questions and Answers

Q.1: This proposed change raises concerns over the delays in claims processing that will occur as well as the additional work it will create. The PM does not address the priority that Coordination of Benefits (COB) will place on the ECRS referrals that will now be associated with this change.

A.1: You are allowed to add the initial "I" record to the CWF as outlined within CR 2240 and CR 2441. If there is an existing record on the CWF, and you are in receipt of different information for the same MSP type, you will submit a CWF assistance request with all applicable information for COBC research/development. This is more advantageous as the development will occur with the entity or entities that sent you the information, not solely the beneficiary, which is the only source of development for an "I" record.

Q.2: Because "I" records are created from refund checks or EOBs that are received with new claims, if we cannot add an "I" record, the claims will have to be pended until 1.) an MSP record is added or 2.) information is received from COB that allows the claim to be processed as Medicare primary. With the influx of these ECRS transactions going to COB, we are concerned that the response time to add the MSP records to CWF or return a response to the contractor via ECRS will create significant delays and more work on the part of the contractors.

A.2: Again, you are allowed to add the initial "I" record as outlined within CR 2240 and CR 2441. If you are not permitted to add an "I" record (voluntary refund/correspondence), and there is no existing "I" record and the information submitted on the MSP inquiry is complete, the record will automatically be added and no processing time will be lost. Regarding the response time and responses from the COBC, we are currently working with the COBC to improve ECRS status timeframes.

Q.3: Contractors will have to access CWF/ECRS periodically to determine whether the record was added to CWF so that the claims could be released for processing. Could the systems maintainers be asked to automatically recycle claims to CWF once it has been moved to a distinct location status so that in the event the record is added to CWF by COB, the claim will release for processing without it requiring manual intervention to release? This would prevent MSP staff from having to check CWF/ECRS periodically to find the status of the ECRS/CWF transaction.

A.3: Currently, there are several options open to contractors. Medicare contractors may check the ECRS response, or wait for the automatic notice sent by the standard system. Please note that both the CMS prepay and postpay MSP components are re-writing CR 1529 (transmittal AB-02-089 previously published as AB-01-18). The revised PM will replace the current paper notification process with an electronic process. This CR is tentatively scheduled for FY 2004 implementation. At this time systems and processing changes relevant to the re-write of this CR are unknown.

Q.4: As other alternatives, can CMS work more closely with those contractors that are the source of many of these erroneous "I" records? In addition, can COB or CWF consider adding edits that will reject the creation of an "I" record unless very specific, more stringent requirements are met? Or, can the "I" record format be revised such that it will provide the additional information needed by COB to conduct further development?

A.4: CMS has been looking at the issue of duplicate MSP records on the CWF prior to the implementation of the COBC. The implementation of the COBC aided in CMS being able to look at this issue with a more centralized and focused perspective. CR 2240 allows for reasonable editing of possible inappropriate and/or duplicate MSP records. In addition, the constraints that have been instituted are necessary to ensure the integrity of the MSP data on the CWF.

Medicare contractors have been given the ability to add one MSP record per MSP type as outlined in the PM. The current limitations of the CWF do not allow the COBC to perform development with sources other than the beneficiary.

Q.5: Why the change in the drafts when it was originally non-GHP and now it encompasses all?

A.5: The changes in the draft and final CR gives Medicare contractors additional flexibility to add MSP records as outlined with the PM. The initial draft was to eliminate the Medicare contractor's ability to add any records once a record was established on the CWF with the same MSP type. That is, there was no 100-day consideration.

Q.6: Will multiple GHP beneficiaries be taken into consideration? The CMS CR does not identify a match on Patient Relationship as part of the criteria for the SP20 reject. However, CWF has included this in their match criteria. Which is correct?

A.6: CWF editing will look at MSP type and patient relationship to ensure that the record is not a duplicate. The COBC will also attempt to add employer name and address information to each MSP record prior to sending or converting a MSP record on the CWF.

Q.7: We received information indicating that there is a problem with CWF where records/updates are not applying. Though it appears to the COBC that "I" records are applying but then the record is not applying. The COBC receives the 01 disposition back, "we applied your transaction", so they assumed it applied, until later when some states it didn't apply.

A.7: A fix has been scheduled for release January 20, 2003. This fix will send the COBC a dump of all "I" records on the CWF and therefore the COBC will be in sync with CWF again. Notice was sent to all RO MSP Coordinators by Danielle Barbour on November 21, 2002 to update Medicare contractors of this issue.

Q.8: What are the time parameters for COB to do the development and what are they going to do if they don't get a response?

A.8: "I" records are initially developed and follow-up development is initiated after 45 days, if no response received to the initial development. The full development cycle is approximately 100 days. If a response is not received the "I" record is deleted and converted to a "Y" validity indicator in most cases. The only outlier to the automatic conversion is in the case of incomplete non-GHP records where no response has been received. Non-GHP records that do not contain dx's, complete insurer and/or attorney information as a result of initial contractor submission and/or COBC development will not be converted to "Y" and lead will not be assigned.

If you submit an ECRS transaction and the initial and follow-up development is performed and no response is received to either development, the response from the COBC will indicate that no response was received and CWF not updated. Please note that the COBC is making internal systems changes to alert them to when ECRS transactions should be moved to another IP status or closed out. This trigger will assist the COBC to monitor their development and follow-up processes and eliminate aged ECRS transactions.

Q.9: What to do with the claim when it is under development at CMS? Where should it go? Could it be considered a dirty claim?

A.9: Danielle Barbour forwarded a response to this issue on 10/17/2002 to all RO MSP Coordinators. The e-mail reference is copied below:

As a result of the transference of MSP prepay development activities to the COBC, Medicare contractors have inquired as to whether claims can be considered "dirty" and placed in a suspense or holding location while awaiting COBC development. We have consistently reiterated through various PM's, the implementation of the COBC did not modify or change existing claims processing guidelines.

Current claims processing guidelines state that claims requiring MSP prepayment development are not clean claims, and are considered "other" claims. The MCM, Part II, section 5240. Standard 1.1.B., and MIM, Part III, Section 3600.1.4 lists some of the criteria that make a claim unclean. Requesting information from an external source (e.g., the physician/supplier), requesting information from another contractor, and developing for M.S.P. information are all listed as conditions which would make a claim "dirty" for CPT purposes.

If it were the pre-COB practice of Medicare contractors to house these "unclean" claims in a particular location while performing development, this practice may continue while awaiting COBC development. In addition, and where applicable, coding of these claims should continue as outlined within the manual citations.

Please share this information with Medicare contractors.

Q.10: When COB changes a record would it be possible for them to use the CWF Remark Codes, to display on the control file? Using the CWF Remark Codes will help others understand why the records were changed.

A.10: This will be considered.

Q.11: The CMS CR instructs Carriers do NOT submit HUSP records to CWF when the record has a "I" validity indicator, and posted to the Beneficiary's MSP CWF file is another "I" or 'Y' record that is (open, closed or deleted) with the same MSP Type, and the Effective Date on the posted occurrence is within 100 days of the Effective Date of the incoming "I" record. MCS does not have the ability to directly edit their files against CWF; therefore, we would not know that the criteria for not sending the file had been met. Would it be sufficient to edit with the same criteria using MCS' MSP files? If the criteria is met within MCS, the file would note be created and would instead be sent via ECRS. If the criteria were not met in MCS, the file would be created and sent to CWF for additional editing against their files. Overall, is the intent of the CR for the MCS to prevent "I" Validity records from going to CWF for the above identified situation, or is the intent for CWF to prevent the record from posting to CWF and provide notification to the carrier that the record should be sent via ECRS?

A.11: Prior to posting transactions to the CWF existing instructions state that Medicare contractors check the CWF to see if there is an existing and related MSP record. Medicare contractors must not rely on their internal standard system. Medicare contractors that do not check the CWF are in direct non-compliance with CMS instruction. The checking of CWF should occur manually or systematically. CR 2240 was implemented because this was not occurring in most instances at the contractor level.

Per CR 2240, CWF editing will not allow the transaction to accrete and you will receive the SP20 error code.

Q.12: The first CR which was distributed in June was to eliminate the application of "I" records for Auto (14), Liability (47), and Worker's Comp (15). The CR stated that the submission of "I" records for these MSP types will be rejected with an SP 20 error code. The most recent CR (distributed in August) has no mention of treating these MSP types any differently from other MSP types, in regards to "I" records submitted to CWF.

Does this most recent CR totally negate the previous one, and will contractors continue to be able to set up "I" records for MSP types 14, 47 and 15; as long as it's in accordance with this current CR's guidelines?

A.12: Medicare contractors have the ability to add one MSP record, per MSP type in accordance with the updated instruction. In addition, Medicare contractors must follow guidelines when adding non-GHP records in accordance with existing CR's.

Q.13: The CR states that an "I" record will only be accepted by CWF 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 on the incoming "I" record. By "closed status," is CMS referring to records with a term date?

A.13: Yes, closed records are records that contain a termination date.

Q.14: If the record on CWF has an "N" validity, will contractors still be able to submit "I" records regardless of the effective date? Are "N" records considered closed records?

A.14: If there is an "N" validity record on the CWF, you will be permitted to add an "I" record. "N" records are not considered, "closed" records. However the only MSP records that will have an "N" validity indicator is an IEQ record that has been developed by the COBC. There may still exists some older records that were applied pre-COBC with an "N" validity indicator.

Q.15: If there are multiple ("I"/"Y") records on CWF for the same MSP type with different effective dates (i.e., one record has an effective date within 100 days from the "I" record we're wanting to submit; but another record has an effective date greater than 100 days from the "I" record we're wanting to submit); what type of situation would take precedence?

A.15: You will not be allowed to submit the MSP record. Additionally, the logic currently in the COBC system should have already deleted all subsequent records with the same MSP type received within the 100-day timeframe.

Q.16: If there are multiple records on CWF for the same MSP type, but one record has an "I"/"Y" validity indicator, and another record has an "N" validity, will the logic for the "I"/"Y" record take precedence?

A.16: The logic for the "I"/"Y" record will take precedence. "N" records are not taken into consideration.

Q.17: Why was a 100-day parameter chosen, as opposed to a 30-day parameter? The 30-day parameter logic is currently used for CWF updates to the carrier (VMS) systems.

A.17: The 100 day parameter was chosen based on analysis performed by the COBC of existing MSP records on the CWF.

Q.18: To whom does the COBC develop for information? Are the development questions clear enough to generate a good response? Does the development process include an auto-time out feature if no response is received?

A.18: Currently, the COBC develops to the beneficiary for “I” records. The questions used are similar to those found on the Initial Enrollment Questionnaire (IEQ) that is a tool that is beneficiary focused-group tested. Development as a result of an ECRS-MSP inquiry is to the beneficiary and provider (for voluntary refund situations). Effective mid-January the COBC will develop to other entities (e.g., insurer, attorney, employer) where necessary as a result of an MSP inquiry. For CWF assistance requests the COBC currently develops with other entities such as the employer. CMS is ensuring that both ECRS type transactions will result in development to the appropriate entities. We have found that development with other entities other than beneficiaries’ results in higher response rates and more quality responses.

Refer to A.8 regarding timing out and record conversions.

Q.19: The CR states that "I" records submitted to CWF that fail to meet the edit criteria will be rejected with an SP20 error code. SP20 is for 'Invalid Validity Indicator'; the "I" indicator is not really invalid, but it's the maintenance transaction that would be considered invalid. Can a more descriptive SP error be used? SP19- Invalid Maintenance Transaction Type or SP50- Invalid function for update or delete. Contractor Number unauthorized.

A.19: The SP 20 error code description has been updated to include the new editing criteria.

Q.20: With the implementation of this CR, contractors will be prohibited from setting up an "I" record when a refund check is received because the COBC would lack the necessary information to develop. The majority of refunds received are from the provider; is it the provider's information that the COBC is wanting? Shouldn't the actual development be to the employer (for GHP records) or to the insurer/attorney (for non-GHP records)?

A.20: The actual implementation and prohibition of submitting “I” records for voluntary refunds are found in CR 2441, AB-02-140, dated October 11, 2002. This CR is effective October 7, 2002. “I” record development is limited to the beneficiary. Therefore, the submittal of employer, insurer, or any other entity through ECRS will allow the COBC to develop with other entities beyond the beneficiary. For example, if a GHP situation is submitted through ECRS and it contains insurer information, however the submission is incomplete, the COBC will develop with the insurer, initially. This change is not restricted to provider development.

Q.21: If the various system maintainers had edits in place that would always require the insurer and employer information to be filled in when establishing an internal "I" record; why couldn't contractors then be able to set up "I" records based on voluntary refunds?

A.21: Most voluntary refunds do not contain enough information to place a complete MSP record on the CWF. Most GHP refunds do not contain the correct effective dates and employer information; therefore, development is still necessary. Additional editing of the insurer and employer fields would not help in these situations. In addition, queries performed on pre-COBC GHP records (excluding IRS/SSA/CMS/Data Match) found most MSP records added by Medicare contractors lacked sufficient employer and insurer information. Based on this historical information, most transactions would result in MSP inquiries even if additional editing were in place. Keep in mind that if the MSP inquiry is submitted with all pertinent and complete information, the record will accrete to the CWF within 24-48 hours. In the case of the GHP refund, if the ECRS submission contains the correct effective date, complete insurer information, and complete employer information, the record will accrete within this time frame. In the case of non-GHP records that contain dx’s, complete insurer and/or attorney information will also accrete to the CWF within the established time frame.

Q.22: Given the 100-day criteria for setting up new files, and the inability to set up new files based on refunds; contractors will have to rely on expedient responses from the COBC. Currently the COBC will develop and confirm all "I" records, and will automatically convert the "I" validity indicator to a "Y" if contrary information is not received within 100 days. Will this 'waiting period' be reduced to 30 days since claims timeliness will be affected? How is the processing staff to handle claims submitted with primary statements, but those claims cannot be processed as secondary because we are unable to set up a control file?

A.22: No, these times parameters will not be changed. The time parameter allows for initial and follow-up development. Regarding how to handle the associated claims, refer to A.9.

Q.23: The above concern applies to adjustments as well; refunds deposited as unapplied cash will cause receivables to age. The actual adjustment cannot be done to credit the refund properly, until the correct file is established in order to get the adjustment claim through.

A.23: This is an MSP postpay inquiry and has been referred to the postpay staff here at CO. Please refer this question to your RO MSP Coordinator for follow-up with the postpay staff, as necessary.

Q.24: How do we handle claims that have discrepancies to CWF? Will we process bases on what CWF has or what we have attached to the claim or hold? If we hold, what about interest? Will we be able to dirty claims for that?

A.24: Any information received by Medicare contractors that is contrary to what is contained on the CWF should be forwarded to the COBC as a CWF assistance request for further investigation. Regarding how to handle the claim refer to A.9. The handling of interest is a postpay issue and should be forwarded to your RO MSP Coordinator. This issue has not been forwarded to the CMS postpay staff at CO.

Q.25: On refunds, CR2240 states to forward the information via ECRS and deposit in misc account until a determination is made. Should another bank account be created?
Will COBC time frame/priority handling for resolution of these be reduced? In reading CR2278, page 11, question 33, unapplied receipts should be researched within 45 days of the receipt of the check.

A.25: The information contained in CR 2240 was updated to reflect that the check should be deposited in unapplied cash. This information was received from MSP postpay. Questions regarding the application of these monies and CR 2278 should be directed to your RO MSP Coordinator.

Q.26: Contractors should be able to create an "I" record for when a beneficiary has two different group health plans (GHP) under himself, as well as having GHP coverage under himself and his spouse. Editing for the SP 20 should be based on the effective date, patient relationship, including insurance type. The patient relationship should be included in the matching criteria. For example:

- Beneficiary has hospital coverage ('J') under BC and medical ('K') under GHI. Since the effective dates for both insurances can be the same, both MSP records should be created.

- Beneficiary has self GHP coverage with Mutual and spousal coverage with Aetna. Since the effective dates for both insurances can be the same, both MSP records should be created.

A.26: CWF will continue to edit on MSP type, patient relationship, and insurer type. This has been forwarded to the OIS-CMS for verification.

Q.27: Can the COBC use phone development rather than written development to obtain information to process ECRS request more timely.

A.27: The COBC currently uses a percentage of phone development for GHP and non-GHP development as a result of CWF assistance requests. Phone inquiries will be instituted in other lines of development work activities where resources permit.

Q.28: If it will be the responsibility of the COBC to reconcile discrepancies and make any necessary modifications to the Common Working File (CWF), what is the time frame that the COBC will do this in? CR 1163 gives the COBC 105 days to develop for MSP information. Would this

requirement be applied to this CR as well? We believe that 105 days is too long of a time frame as the impacts would be:

- Increase in pending claims. This means delaying payments on claims where partial payment is expected, and not tracking the beneficiary's benefit period accurately (partial and no-pay claims). Partial claims will pay interest.

- Increase in ECRS requests. This could create extra follow-up activities. If the ECRS generates a new report that would list the outstanding and resolved ECRS requests for a contractor, it may reduce the number of follow-ups sent to the COBC. This request has been previously made.

- Increase in MSP prepay activities (additional funding will be needed by contractors).

- Increase in MSP postpay activities (additional funding will be needed by contractors) as claims being cost-avoided will decrease.

- Increase in pending adjustments when checks are received on liability cases (e.g., malpractice) where there is no MSP file on CWF. The adjustments are processed to show the money received and to take savings.

A.28: The 100 day processing timeframe applies to CR2240. With the implementation of this CR, CMS does not anticipate additional funding needs for MSP prepay or postpay activities based on CR 2240. Please note that CMS will monitor the effects of CR 2240 and its possible impact on Medicare contractor workloads, as well as the MSP budget.

The new updates in ECRS 5.1 allow for the timely application of non-GHP cases, particularly when the check received by the Medicare contractor opens and closes the case in one action. The handling of pending claims is discussed in A.9.

Q.29: Will the invalid "I" records currently pending at CWF be resolved before this is implemented?

A.29: We are not sure what you mean by "invalid I records". The COBC has systems logic in place to delete duplicate records. If you are referring to incomplete "I" records that were not confirmed by the COBC, these records will be converted automatically to "Y" after 100 days in accordance with the rules pertinent to GHP and non-GHP records as discussed throughout this CR. Currently, incomplete non-GHP records do not convert to "Y" records when there is no response to development. These records are not converted because lead will be assigned based on incomplete data. CMS will make a final determination regarding how the COBC should handle these types of situations.

Q.30: Will the COBC consider developing to the employer to obtain GHP coverage information as done in the IRS/SSA/Data Match process? Recovery of mistaken payments is initiated to employers. Why not make the employer a part of the process from the beginning.

A.30: Refer to A.18.

Q.31: Will carriers hold the case open and wait for the "I" record to complete the case or close the case and explain to the inquirer that the COB needs to update the files before we can complete the review.

A.31: If the "I" record, CWF assistance request, or MSP inquiry is case related, explain to the inquirer that they may follow-up with you within 100 days (this in the case where development must occur), or they may phone the COBC directly at 1-800-999-1118. In the case where you have submitted a CWF assistance request or MSP inquiry and the information is a simple add or update, (requiring no development), the inquiry will be processed within 24-48 hours in accordance with the rules pertinent to GHP and non-GHP records as discussed throughout this CR.

Q.32: What criteria does COB use to determine whether a D, E, or L trailer should be established?

A.32: The COBC uses the same rules of identifying MSP cases that all Medicare contractors used. In addition, information received through "I" records and MSP inquiries from Medicare contractors determine whether a MSP record should be added. Obviously, in cases of discrepancies or skeletal information being submitted the COBC will have to take additional steps to develop or investigate the inquiry.

Q.33: What additional information is received from the ECRS transaction that is not received from the carrier initiating an "I" record?

A.33: Previously we indicated that the following fields were mandatory in order to add "I" records to the CWF:

Health Insurance Claim Number
MSP Type
Validity Indicator
MSP effective date (If the actual effective date is not known, you may use the Part A effective date)
Contractor identification number
Insurer Name
Patient Relationship
Insurer Type

If you compare the above to the ECRS 5.1 manual, you will find what additional fields are available or required on ECRS transactions as opposed to the MSP record on the CWF. Please keep in mind that listed above are the required fields for you to submit an "I" record, however the criteria used by the COBC to establish a complete record on the CWF requires more detail, specifically for non-GHP records, since there is the lead assignment process to consider also.

Q.34: The Medicare Part B carriers feel that the automated process that is used by the Part A Intermediary system to establish MSP trailers is causing most of the erroneous records that are being sent to CWF. Should the Part A system be updated to no longer allow the automated process of sending MSP trailers to CWF?

A.34: The ultimate fix is to alter the standard systems processing of these records, however this CR will resolve many of the "I" record issues occurring today.

Q. 35: Would you please provide the carriers with the type of problems that have been identified with the creation of "I" records. Is this Carrier or Intermediary specific?

A.35: Freely allowing Medicare contractors to post "I" records that are incorrect and duplicative result in inappropriate Medicare payments, beneficiary and provider complaints, and a reduction in the integrity of the information contained on the CWF. This issue is the result of both carrier and intermediary actions.

Q.36: Has any education been provided to the carriers or intermediaries that are abusing or incorrectly establishing these records?

A.36: Yes, through various CMS forums.

Q.37: The CR states, '…where intermediaries and carriers previously submitted "I" records for MSP types D, E, and L they should now transfer all available information concerning the case to the COB contractor via the ECRS MSP inquiry screen.' Is this statement just clarifying the new process or will carriers be expected to look at all the "I" records they have pending and send the information through ECRS?

A.37: The CR has been updated to incorporate all MSP types. CR 2441, effective October 7, 2002 indicates that Medicare contractors should no longer submit "I" records where they receive voluntary refunds and checks. This information is also documented in CR 2240, effective January 1, 2003.

"I" records previously submitted to the CWF should not be resubmitted as ECRS transactions unless you are in receipt of additional information.

Q.38: Will a new source code be added to ECRS that would allow carriers to submit an inquiry based on information received from a primary EOB?

A.38: ECRS has always allowed for Medicare contractors to submit and identify inquiries that are the result of an EOB by utilizing the "SCLM" source code.

Q.39: Based on carrier observation, COB is setting up invalid "I" records. For example, COB contractor numbers 11108 and 11109 is setting up D and L records with the same effective date. By implementing this CR carriers are not sure the problem with invalid "I" records will be resolved.

A.39: Contrary to popular belief, the COBC does not have the systematic capability to add "I" records to the CWF. When "I" records are automatically converted to "Y" records, the COBC deletes the existing "I" record and adds the "Y" record with the same information.

Q.40: What is the CPT expectation for processing correspondence while waiting for COBC to establish the MSP record?

A.40: Any development that has been referred to the COBC and is the responsibility of the COBC should not be included in your CPR time frame.

Q.41: When a claim is received with a primary explanation of benefits (EOB) attached from a third party payer and CWF does not show a D, E, or L trailer, carriers will have to determine how to handle the claims. To suspend the claims until COB can establish the record on CWF to allow the claim to be priced secondary or enter the information from the EOB in ECRS, ignore the EOB and allow the claim to pay? These claims will potentially require interest payments because of the delay in processing.

A.41: In non-GHP cases, claims are primarily either denied or paid conditionally as primary. If there is no MSP record on the CWF related to the MSP situation, then you will be allowed to add the record in accordance with CR 2240 and CR 2441. In all other cases, follow the guidelines for ECRS transactions. Refer to A.9 regarding handling claims while awaiting COBC development.

Q.42: To be HIPAA compliant, carriers must accept EMC claims with MSP information. If we cannot add "I" records, we will have to suspend the claim OR remove the MSP information, (alter an original claim, which would not be compliant with the MCM), and process the claim for payment. Either way, the claim examiner will need to enter ECRS to have the MSP record created which is more time consuming than entering the "I" record, (with the same information we will be sending via ECRS). Providers will be calling IRATE because they are not receiving their payments timely. Carriers will be paying interest on claims they are holding, waiting for the trailer to be established.

A.42: Duplicate or inappropriate "I" records in accordance with CR 2240 will not be accepted to the CWF. If the provider is billing correctly (i.e., in accordance with the existing and valid record on the CWF), there should exists no conflict in processing the claim. Where the provider is not billing correctly or additional development is required, the claim will result in Medicare contractor action. The resultant action will be to perform additional training with the billing provider after you determine that the claim was in fact billed incorrectly, or to submit an ECRS transaction to the COBC. Refer to A.9 regarding handling claims while awaiting COBC development.

Q.43: If a carrier sends an ECRS transaction, and COB incorrectly sets up the "I" record with the wrong trailer (D, E, or L trailer), will all carriers be able to request the update of these MSP trailers or will the 'lead carrier' be required to send a correction to COB. Once again, the beneficiary is

severely impacted because all the claims are impacted, and they have to wait for the update of the "I" record. This is happening today, but will just intensify.

A.43: The COBC does not set up "I" records on the CWF. If a non-GHP ECRS transaction is received and is complete, a "Y" MSP record will automatically be loaded to the CWF by the COBC as received. Once this record is loaded and lead determined, only the lead contractor can request a change to the record. This change in MSP type occurs within 24-48 hours therefore there is no impact to the claim process.

Q.44: Will the Part A system be required not to allow "I" records to be created automatically when a claim comes in with this information. If no file will be created, the claims will suspend stating no MSP file, but there is MSP information on the claim. This will be a workload issue for contractors, because these claims currently do not stop.

A.44: Refer to A.42.

Q.45: If we are suppose to remove the MSP claim information per CMS, can CMS create a standard EOB message that we can send to the provider letting them know we removed the primary insurance information and they should not send a review request to adjustment their claims until CWF has been updated. If CMS creates this message the influx of calls might decrease because the provider would be aware of the reason contractors removed the primary insurance information. Contractors wouldn't have as many irate callers if they knew CMS instructed contractors to do this.

A. 45: We are researching the accuracy of the statement regarding the contractor's ability to remove primary payer information before we provide a final response to this question.

Q.46: Contractors would send all information through ECRS to support the reason why a file should be created. Would the turn around time decrease for research on these files since we could be paying a lot of claims as primary when we could be having a lot of MSP savings.

A.46: ECRS allows for Medicare contractors to identify the source of their information. In addition, any information that you receive should be submitted to the COBC within your ECRS transaction. Regardless as to the source, it still remains the responsibility of the COBC to determine whether a record should be accreted to the CWF or updated. Medicare contractors have the ability to add one MSP record, per MSP type as stated within CR 2240. If you do not agree with the actions taken by the COBC on a particular request, you are encouraged to contact your COBC consortia representative. Lack of follow-up by your consortia rep should be reported to your RO MSP Coordinator.

Q.47: This situation would create more interest for all contractors since we are paying claims primary and a provider is actually notifying us of an automobile/workers comp case. When the file is actually created, the lead contractors would then compile all of Medicare's payment. When doing this, we could be including claims that the provider actually tried to bill as secondary, but we paid as primary. Isn't this more of a risk factor of not getting all of our money back and paying out more money until the case is settled?

A.47: This question is not clear. You are allowed to post the initial "I" record per CR 2240. Again, there is also a 100-day time parameter from the effective date of the initial and related MSP record on the CWF to submit another non-GHP record. Again, there are no processing time implications if the issue falls within the 100-day time frame if you have complete information to submit an ECRS transaction.

Q.48: Since the contractors will be unable to add "I" records for 14, 15 and 47 this will cause an increase in the number of ECRS transactions the contractor will need to send which will be a workload issue for both the contractors and COB.

A.48: If there is no MSP record on the CWF related to the MSP situation, then you will be allowed to add the non-GHP record in accordance with CR 2240 and CR 2441. Keep in mind the instances (refer to A.70) in which you are allowed to submit an "I" record.

Q.49: We have concerns regarding COBC responses, CM 72, CM 73, and CM 76 for non-GHP situations where we have evidence of record of payment from the auto insurer.

A.49: Where you have complete information in a non-GHP situation (i.e., dx codes, insurer and/or attorney, and DOI), the transaction submitted (i.e., I record, MSP inquiry, or CWF assistance request) should be complete; therefore there is no need for COBC development. If the refund is from a provider, the COBC will develop to the provider as a result of an MSP inquiry where development is necessary.

In cases where you receive a response that you believe to be incorrect, you may resubmit as a CWF assistance request for further development. In addition, you may add comments to the request to support your request for re-development.

Q.50: What line should claims received with an EOB be reported to 11101 or 22001?

A.50: Initial claim entry includes keying of primary payer's EOB/RA payment data is not a MIP, MSP charge. This should not be reported in 22001. This cost is reported under Bills/Claims Payment, 11101. Refer to the FY 2003 BPRs for more information.

Q.51: How long will carriers be required to wait for the MSP records to be established in CWF?

A.51: This depends on what you mean by "established". Most "I" records are converted to "Y" records within 100 days (i.e., GHP). If the transaction is sent via ECRS the final reason code within ECRS should occur within 100 days. The final ECRS status will indicate whether a MSP record has or has not been applied to the CWF.

Q.52: Will COB notify carriers if "I" records will not be built? If "I" records are not established by the COB contractor, who will notify the beneficiaries or providers that Medicare should be the primary insurance and a refund should be sent to the TPP?

A.52: Again, the COB does not build "I" records. If an "I" record is submitted by a Medicare contractor it is applied automatically. If the "I" record is returned as a result of CR 2240, you will have to establish an ECRS transaction, if applicable. The final ECRS status will indicate whether a MSP record has or has not been applied to the CWF.

Q.53: Carrier Post Payment Review areas will not be able to adjust any claims unless the "I" record has been established. Again, should carriers hold the case open and wait for the "I" record to complete the case or close the case and explain to the inquirer that COB needs to update the files before we can complete the review.

A.53: This is an MSP postpay inquiry and has been referred to the CMS CO postpay staff. Please refer this question to your RO MSP Coordinator for follow-up with postpay staff, as necessary.

Q.54: If we close the case, and the "I" trailer is opened past the 6 months time frame for a review request, will the untimely review guidelines be updated to allow this scenario to be a valid reason to reopen an untimely review?

A.54: This is an MSP postpay inquiry and has been referred to the CMS CO postpay staff. Please refer this question to your RO MSP Coordinator for follow-up with postpay staff, as necessary.

Q.55: The Financial Accounting area will face the same problems. If they receive an unsolicited refund, and it involves claims for a D, E or L file, they will not be able to work the cash receipt until the "I" record is established and they can adjusted the claims involved (Per HIPAA guidelines).

A.55: Per postpay instruction, unsolicited refunds should be deposited to unapplied cash until the COBC makes a determination. Further inquiries should be directed to your RO MSP Coordinator for follow-up with the CO MSP postpay staff, as necessary.

Q.56: On the 8/28/02 VMS MSPTAG call that Harry Gamble attended, he stated that if 100 days have passed and the COB has exhausted every aspect and there is still no response, then COB will tell us that they can't apply the record. However, the current process used by the COB is to go ahead and build the "I" record if no response after 100 days. Does this mean that with CR2240; if after 100 days and no response, when COB will tell us they can't apply the record, that we will then be able to set up an 'I' record? If so, then will we end up waiting an additional 100 days while COB re-investigates the same record; causing the piece to be pended for up to 200 days?

A.56: With the implementation of CR 2240 this process will not change. Medicare contractors will not be advised that a "Y" record will not be posted. Refer to A.40 regarding conversion of "I" records.

Q.57: Referencing the above when applying to voluntary refunds and the time frame for holding unapplied receipts, the financial instructions (CR2278 p.11, q.3) state that money should be applied after 45 days. Will these instructions be modified in accordance with CR2240?

A.57: This is an MSP postpay inquiry and has been referred to the CMS CO postpay staff. Please refer this question to your RO MSP Coordinator for follow-up with postpay staff, as necessary.

Q.58: We have not seen confirmation on whether or not we can place claims in a "dirty" status while waiting on response from the COB. Will this be an acceptable process?

A.58: Refer to A.9.

Q.59: Just for clarification, is the first memorandum regarding the total inability for contractors to set up Non-GHP records (types 14, 15, and 47) eliminated?

A.59: CR 2240 has been updated and "I" records are permitted in non-GHP situations.

Q.60: If the only record(s) at CWF have validity indicators of "N", will contractors be able to set up 'I' records regardless of MSP type or effective date?

A.60: Yes.

Q.61: If there are multiple (I/Y) records on CWF for the same MSP type but with different effective dates (i.e., one record has effective date within 100 days of the record we're wanting to submit, and another has an effective date greater than 100 days of the record we're wanting to submit); will the existence of just one record that is within 100 days of the record we're wanting to submit take precedence?

A.61: In the situation that you describe above, the record that you are attempting to submit will reject.

Q.62: If COB has the ability to enter data on the detail (MSPD); can they not utilize the CWF remark codes when terming or deleting a file? This would be in addition to use of the expanded reason codes that COB is to use for ECRS transactions.

A.62: Refer to A.10.

Q.63: The SP20 definition is to be modified for use with CR2240; the current definition is "Invalid Validity Indicator". Since this could still be a valid error transaction, why can't SP19 (Invalid Maintenance Transaction Type) or SP50 (Invalid function for update or delete. Contractor Number unauthorized) be returned when contractors attempt to submit an "I" record within the 100 day timeframe?

A.63: SP50 is not appropriate as this code is only applicable to updates and deletes. The action that you would be performing is an "add".

Q.64: The provider can submit a claim with an attached EOB, and the claims area will be able to set up an "I" file. Yet if the provider submits a refund on a claim Medicare paid as primary incorrectly, with an attached EOB; the refund area cannot set up an "I" file. Why are the rules different, depending on whether the claim (or copy of) and EOB are submitted front-end or back-end?

A.64: In most instances, provider refunds do not contain the source of the entity that returned the refunds, therefore adding an "I" record does not provide sufficient information for the COBC to develop to the most appropriate entity. The adding of "I" records only allows the COBC to develop to the beneficiary.

Q.65: If we educate providers to send the name and address of the primary payer (with the refunded or returned check) may we add the MSPI record if applicable?

A.65: CMS believes that this type of education should have occurred with providers pre- COBC, reducing overall development efforts by Medicare contractors. Providing this type of education would diminish the need for COBC development, and MSP records will be accreted to the CWF sooner. If this information is submitted, the Medicare contractor will be able to submit complete ECRS MSP inquiries, which would result in the CWF record being established by the COBC within 24-48 hours.

Q.66: When we receive a data match tape, not all of the MSP records are at CWF. Should an ECRS request be done before the data match letter is sent or after the response is received? If after, there may be a delay in processing adjustments.

A.66: This PM does not alter the data match recovery process.

Q.67: The COBC should contact contractors for documentation before deleting an MSP record when no response is received to their development letters. This could be accomplished by a report listing the ID of the person who keyed the request, or (even better), a new source code could be added to ECRS that would allow contractors to submit an inquiry based on information received from a primary EOB or other documentation. ECRS could then set a new action code requesting documentation from the person who keyed the request. In addition, we previously asked for a new report listing the outstanding and resolved ECRS requests for a contractor (in order to reduce the number of follow-ups sent to the COBC).

A.67: The COBC does not delete MSP records on the CWF when there is no response to development. "I" records are deleted based on negative development responses from beneficiaries, requests by Medicare contractors and or entities that the COBC has developed to. In ECRS if there is no response to the COBC's development, the status/reason codes returned on the ECRS transaction will indicate that there was not response to the development. We gave Medicare contractors the ability to screen print ECRS transactions in particular statuses for tracking purposes. The COBC is not charged with furnishing ECRS status reports to Medicare contractors.

When submitting ECRS transactions related to an EOB, you should submit your request with the "SCLM" source code. In addition, all ECRS transactions submitted to the COBC should indicate and display all information that you received. There is minimal need for the COBC to request Medicare contractor documentation on file, if all information has been given on the ECRS transaction. After the January 2003 COBC release, the COBC will develop to all available entities that are noted on the ECRS transaction. This change in development should improve the COBC's ability to substantiate the MSP situation resulting in a MSP record being added to the CWF.

Q.68: CR 1163 specified how contractors should set up MSP effective dates, but FISS did not make system changes to prevent existing default dates (possibly due to time constraints). Will CMS require FISS to make the system changes for CR 1163? PARS NY 1499 and NY 1399 were updated to include CR 1163. In addition, PARS MA 1577 and AR 0049 address issues with updating the MSPA files. These PARS need to be worked regardless of CR 2240, and are on out TOP FIVE list.

Will CMS considered rescinding CR 2240 if it causes an unreasonable backlog, and FISS addresses the problems with default dates and matching criteria?

A.68: CR 1163 is now an obsolete PM, therefore cannot be referenced in this response. Standard systems changes related to adding MSP records will be covered in a future PM. Making these changes in FISS moves in the direction that CMS supports with establishing and requiring specific editing (future CR) in all standard systems. CMS has not considered rescinding CR 2240 in lieu of these FISS changes.

Q.69: CMS needs to address edits for creating MSPI records. At one time CWF and FISS Were consistent in their edits for creating and updating MSPI records. However, there have been many edit exceptions granted to special contractors. As a result, FISS does not always add the records. As an example, the COBC added an insurance "K" record when there was an existing insurance "A" record for the same effective date. In addition, the COBC added an MSPA liability record with a different patient relationship and no term date (instead of correcting the patient relationship and removing the termination date). FISS does not allow records that have the same MSP code and the same effective date for non-EGHP MSPA records, regardless of the relationship. If CWF is going to allow these records, them FISS needs to change their system to accept them. We had closed some PARS in anticipation of PAYER ID. CMS needs to establish consistent COBC edits and unique matching criteria for adding and updating records-which needs to be accepted by all standard systems.

A.69: CWF "I" validity record editing processes are currently under review.

Q.70: In what instances may contractors add non-GHP and GHP records to the CWF? Can we add as a result of CORR received?

A.70: Medicare contractors may add an initial "I" record in cases where you are processing claims for secondary payment or conditional payment. Medicare contractors have never been extended the authority to add "I" records as a result of CORR received. In addition, with the implementation of CR 2441, AB-02-140, "I" records are no longer permissible as a result of voluntary refunds or checks. This change in process is also documented in CR 2240. Additional instructions are included regarding what type of ECRS transactions should be submitted in lieu of an "I" record.

The effective date for this Program Memorandum (PM) is February 7, 2003.

The implementation date for this PM is February 7, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.