Program Memorandum Intermediaries/Carriers

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

Transmittal AB-03-101 **Date: JULY 18, 2003**

CHANGE REQUEST 2801

SUBJECT: Clarification for CR 2562: Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

Effective October 1, 2003, Common Working File (CWF) will implement the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based Managed Care Enrollment coding files described in current CMS Systems CWF manuals.

Upon receipt of notification that a beneficiary has previously enrolled in a Managed Care Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive Managed Care enrollment. The CWF will compare the period between the Managed Care enrollment start date and the **date of service** of the claims in history. Services that fall within the responsibility of the Managed Care Organizations will be identified.

The CWF will generate an informational unsolicited response, with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based Managed Care payment rules. The informational unsolicited response will have all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the Health Insurance Claim number. The CWF will electronically transmit this informational unsolicited response to the contractor that originally processed the claim. The informational unsolicited responses will be included in the existing CWF response file. The unsolicited responses in that file for claims to be adjusted will be identified with a unique transaction identifier. The previously submitted claim will not be canceled and will remain on the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the informational unsolicited response the **Shared System** software will read the trailer for **each claim** and either a manual or automated adjustment will be performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.

Carriers

When CWF identifies the fee-for-service claim on history, the deductible will be updated on the beneficiary's file, and the corrected deductible information will be returned to the carrier in trailer 11. To recover any monies due back to Medicare resulting from these denials, carriers should follow the criteria in the overpayment recovery instruction in the Medicare Carriers Manual, Part 3, §§7100-7104 and §§7116-7130 for the policy guidelines for furnishing demand letters and granting appeals rights.

In the event that a denial is reversed upon appeal, for carrier claims, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Fiscal Intermediaries (FIs)

When CWF identifies the fee-for-service claim on history, the claim will be returned to the fiscal intermediary in trailer 11. The deductible will be updated on the beneficiary's file and the corrected deductible information when the claim is adjusted. To recover any monies due back to Medicare resulting from these denials, FIs should follow the criteria in the overpayment recovery instruction in the Medicare Intermediary Manual, Part 3, §§3707-3710 for the policy guidelines for furnishing demand letters and granting appeals rights, following current consolidated billing procedures.

In the event that a denial is reversed upon appeal, a new 1 byte override code field will be created at the header level for FI claims. The FIs should use override code "1" in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the new HMO override field. The purpose of using "1" or "2" is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a Managed Care Plan, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an alternate method).

This beneficiary was enrolled in XXXXXXXXXXXXXX, a risk-based Managed Care Organization (MCO), for the date of service of this claim. You must contact the MCO for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS Internet at **http://www.cms.hhs.gov/healthplans/reportfilesdata/claimsaddrs.asp**

Due to current system limitations the VMS Shared System Maintainer cannot carry the managed care organization name or designator.

When the VMS Shared System Maintainer is able to carry the 5 character MCO designator, VMS should use: This beneficiary was enrolled in a risk-based Managed Care Organization (MCO) for the date of service of this claim. You must contact the MCO, XXXXX for the payment of these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS Internet at **http://www.cms.hhs.gov/healthplans/reportfilesdata/claimsaddrs.asp**

New Medicare Summary Notice (MSN)

The MSN code 16.57- Medicare does not pay for this item or service since our records show that you were in a Medicare+Choice Plan on this date. Your provider must bill this service to the Medicare+Choice Plan.

16.57 - Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Su proveedor debe facturar este servicio a el plan de Medicare + Opción.

Provider Notification

A national Provider Education article related to "Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment" will be sent as a separate instruction.

The effective date for this Program Memorandum (PM) is October 1, 2003.

The implementation date for this PM is October 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2004.

If you have any questions, contact Carol Eaton at 410-786-6165.