CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 555

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: MAY 2, 2005

Change Request 3866

SUBJECT: Fiscal Intermediary (FI) Reporting of Add-on-Payments that do not Result in a Specific Increase or Decrease in the Amount Reported as Payable for a Claim or a Service on a Remittance Advice

I. SUMMARY OF CHANGES:: This Change Request clarifies information for FIs for reporting of information used to adjudicate a claim or service but which does not result in an increase or decrease in the allowed amount and payment reported for the claim or service in a remittance advice. Information that does not increase or decrease the allowed amount and payment must be reported in an informational (AMT) segment that is excluded from balancing calculations, rather than a claim or service adjustment (CAS) segment which must be included in balancing calculations.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 01, 2005

IMPLEMENTATION DATE : October 03, 2005

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	22/20/General Remittance Completion Requirements

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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SUBJECT: Fiscal Intermediary (FI) Reporting of Add-on-Payments that Do Not Result in a Specific Increase or Decrease in the Amount Reported as Payable for a Claim or a Service on a Remittance Advice

I. GENERAL INFORMATION

Upon investigation of provider complaints about widespread use of reason code A7 (presumptive payment adjustment) in Medicare remittance advice transactions to force balance the transactions, CMS recently became aware that currently FIs report the add-on-payment(s) in the claim/service adjustment segment as additional payments when the additional payment is already included in the allowed amount. This creates an out-of-balance situation that is corrected by an offsetting entry in the same amount with code A7. Add-on-payments are "Internal" adjustments - actions that factor into the adjudication of a claim and which may affect the reported allowed amount or the payment issued to the provider for the claims reported upon in a remittance advice, but do not result in an increase or a decrease in the payment calculated as due for a particular claim or service contained in a remittance advice. "Internal" adjustments of this nature currently include cost outlier, hemophilia, new technology, and electroconvulsive therapy supplements which the Fiscal Intermediary Shared System (FISS) includes in the allowed amount.

A. Background: FIs currently report "internal" adjustments in service or claim level adjustment (CAS) segments in their remittance advice transactions. Since those "internal" adjustments are already reflected in the allowed amount(s) and the payment separately calculated and reported for those claims/services by FISS, reporting of that information in a CAS segment results in double counting of those amounts. This prevents those remittance advice transactions from balancing without the use of A7 to counterbalance the duplicate amount reported. This transmittal is instructing the FIs and the Shared System Maintainer (FISS) to report these add-on-payment adjustments in the appropriate claim or service level supplemental information (AMT) segment only, and not in the CAS segment. The wording in Medicare Claims Processing Manual, Chapter 22, §20 has now been revised to better clarify the X12 835 implementation guide expectations and the CMS requirement for reporting of such "internal" adjustments. The companion document will also be updated to include Electroconvulsive Therapy (ECT) in AMT02 field, and the updated companion document will be posted at:
http://www.cms.hhs.gov/providers/edi/hipaadoc1.asp

B. Policy: "Internal" adjustments that do not increase the allowed amount or payment reported in a remittance advice as due for a claim or service must be reported in an AMT segment, and not in a CAS segment, in a remittance advice.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3866.1	FIs will show the add-on-payments (New Tech/ECT with qualifier ZL, Inpatient Outlier with qualifier ZZ, and Hemophilia with qualifier ZK) in the appropriate AMT segment. FISS will make the necessary programming changes so that these amounts are not entered in the CAS segment and are not included in the balancing calculation.	X	X			X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3866.2	A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** Sumita Sen sumita.sen@cms.hhs.gov 410-786-5755 **Post-Implementation Contact(s):** Sumita Sen sumita.sen@cms.hhs.gov 410-786-5755	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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20 - General Remittance Completion Requirements

(Rev. 555, Issued: 05-02-05; Effective: 10-01-05; Implementation: 10-03-05)

The following general field completion and calculation rules apply to both paper and electronic versions of the remittance advice, except as otherwise noted. See the current implementation guide for specific requirements:

- *Any adjudicative action that increases or decreases the submitted charge and/or units reported by a provider in a claim must be reported in a service and/or claim adjustment (CAS) segment with the appropriate group, reason, and remark codes to explain the positive or negative adjustment.*

  An adjustment must always be reported at the lowest level possible. If service level data is included in a remittance advice for a claim, an adjustment to that service must be reported in a service level CAS segment. An adjustment reported in a service level CAS must not be separately reported in a claim level CAS for the same claim. That would result in duplicate reporting and prevent the transaction from balancing.

  Every adjustment that applies to a provider's payment, but which is not directly related to the patients whose claims are reported upon in the remittance advice, (e.g., the withholding of an amount a provider was previously overpaid or a reduction for late claim submission by a provider, or payment of interest to a provider for late payment of claims) must be reported in the PLB segment with the appropriate reason code to explain each applicable increase or decrease reflected in the net payment issued the provider for that remittance advice.

  Add-on-payments that are already included in the Medicare allowed amount reported for a claim or a service (e.g., new technology) and do not result in payment of a supplement in addition to the reported allowed amount , must be reported in the appropriate claim or service level AMT segment only with the appropriate reason code as indicated in the implementation guide and not in a CAS segment. Data reported in any AMT segment is excluded from remittance advice balancing calculations.

- The computed field "Net" must include "ProvPd" (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.
- The Medicare contractor reports only the name of the immediately subsequent payer on the remittance advice, even if coordination of benefits (COB) information is sent to more than one payer. (The current HIPAA compliant version does not have the capacity to report more than one crossover carrier.)
- The check/*EFT* amount is the sum of all claim-level payments, including claims and service-level adjustments, less any provider level adjustments.
- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.
- The contractor does not issue an RA for a voided or cancelled claim. It issues an RA for the adjusted claim with "Previously Paid" (CLP04 in the 835) showing the amount paid for the voided claim.