Incarcerated Beneficiary Claim Denial

Frequently Asked Questions

BACKGROUND

Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated or in custody under a penal statute or rule at the time items and services were furnished. For additional information about this policy, please refer to the Medicare Learning Network's recent "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet (ICD 908084).

Recently, CMS initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated or in custody on the date of service. For these recoveries, CMS identified previously paid claims that contained a date of service that partially or fully overlaps a period when a beneficiary was apparently incarcerated based on information from the Social Security Administration (SSA). As a result, a number of overpayments were identified. In some cases demand letters were released with appeals instructions, and, in many cases, automatic collections of overpayments were made. However, CMS has since learned that the information was, in some cases, incomplete for purposes of collection.

CMS understands that this issue has been challenging for providers and beneficiaries, and we are actively addressing it. We have restored the original data on the Medicare Enrollment Data Base. Any new claims that are denied on or after October 28, 2013, because the beneficiary was incarcerated on the date of service, are based upon that information. We are also identifying all of the claims that were incorrectly demanded or collected, making changes to claims processing systems, and refunding amounts collected. This process will identify the claims that were denied in error and reprocessing will be completed by the Medicare Administrative Contractors.
Last updated 11-27-13

RESOLUTION TIMEFRAME AND PROCESS

Q1: How is CMS resolving the claims denial issues associated with the June, July, and August 2013 incarcerated beneficiaries' data?

A1: The resolution of this situation requires a series of complex actions, including the restoration of the original data on the Medicare Enrollment Data Base (EDB), the identification of claims that were incorrectly denied or cancelled, the determination of amounts that will need to be refunded, and making changes to our claims processing systems to update Medicare history and notify the other users of our data, such as secondary insurers. The EDB data has been updated and CMS has reduced related non-supplier open accounts receivable to zero in

the majority of instances. Most suppliers will receive refunds by the first week in December. Refunds for non-supplier providers will begin to be issued during the first week in December and the majority should be issued by the middle of December. Note that accounts receivable related to claims that have been appealed are not impacted by this action; appealed claims will be handled separately and, where appropriate, refunds will be generated at a later date.
Last updated 11-27-13

Q2: As part of the reprocessing work to correct the erroneous claim denials, is Medicare reviewing the claims that were denied on a daily basis between CWF updates during June, July, and August 2013?

A2: Yes. Now that the up-to-date incarcerated beneficiary data from the Social Security Administration has been loaded into its systems, CMS has instructed its Medicare Administrative Contractors (MACs) to reprocess any claims that may have been denied on or after May 1, 2013 through October 28, 2013, to ensure that the denial was correct. If the original denial was in error, the MAC will adjust the claim to pay. All of the reprocessing should be completed no later than the end of December 2013.
Last updated 11-20-13

Q3: Were providers notified of which accounts receivable were closed?

A3: No.
Last updated 11-27-13

Q4: Were all of the accounts receivable associated with the erroneous claim denials/cancellations closed?

A4: No. Most of the accounts receivable for erroneous provider claims denials/cancellations were closed. However any accounts receivables in an appeal, bankruptcy, fraud or CMS hold status were not closed. Finally, a group of accounts receivable for affected professional provider claims that haven't been closed will be closed by the Medicare Administrative Contractor. The timeframe for this activity is not yet finalized.
Last updated 11-27-13

Q5: If an accounts receivable was not closed, does that mean that the overpayment is valid and will be pursued using normal procedures?

A5: If an accounts receivable was not closed and does not fall into one of these groups, appeal, bankruptcy, fraud or CMS hold status, the providers and suppliers should assume that the overpayment is valid and it will be recouped using normal procedures.
Last updated 11-27-13

Q6: Will the overpayment letters/demand letters that went out for the claims that were subsequently reprocessed be rescinded?

A6: No. This action is not necessary because the Accounts Receivable was closed if the demand was not paid, or refunded if the demand was paid.
Last updated 11-27-13

Supplier Claims (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies billers)

Q1: When will the supplier claims be reprocessed?

A1: The supplier claims that were incorrectly denied will be adjusted and paid by the DME MACs, using normal procedures, including closing out the relevant accounts receivable. Suppliers should receive payments for most of the adjusted claims by the first week in December 2013.
Last updated 11-20-13

Q2: How will a supplier be able to identify affected claims that have been reprocessed?

A2: For supplier claims, the remittance advice will have information in the Claim Payment Information (CLP) segment. For the reprocessed claims, the two fields in this segment will include the following information:

- CLP01 – Patient Control # – The value in this field will be identical to any value received on the original submitted claim (CLM01 on the X12 837). Suppliers can use this information to assist in matching the reprocessed claim with the original claim.
- CLP02 – Qualifier 22 – Reversal of previous payment. This qualifier will be used because the current payment is reversing the previous payment of $0.00 in case of previous denial.

Last updated 11-20-13

Q3: When will a supplier be notified which claims are going to be reprocessed?

A3: The supplier will not be notified in advance of the reprocessing as to which claims will be paid. Suppliers will be receiving a remittance advice which will identify the affected claims and which can be used to reconcile their books.
Last updated 11-20-13

Q4: When will a supplier receive payment for the reprocessed claims?

A4: The majority of the supplier claims will be reprocessed and the payments issued no later than the first week in December 2013.
Last updated 11-20-13

Q5: What does it mean if I do not receive a refund?

A5: There are several explanations for not receiving the refund you were expecting. The refund might have been applied to an outstanding overpayment or accelerated/advanced payment. If this is the case, the remittance advice should provide the necessary information. Appeals are being handled through a separate process and refunds will be issued if the original claim denial was determined to be incorrect. The DME Medicare Administrative Contractors are also still working to identify further refunds for some claims which have had one or more previous adjustment actions, and recoupments on which interest was accessed and collected. If none of these situations is applicable, it indicates the overpayment was correctly assessed.
Last updated 11-27-13

Q6: After reprocessing occurs, will the payments made to the affected suppliers match the amounts recouped for the inappropriately denied claims?

A6: The repayment may not exactly match the original payment that was made for the claims. The claim repayment amount or refund is subject to normal CMS business processes. In other words, the refund when processed by CMS may be used to offset or recoup against any outstanding overpayment that may currently exist. If this occurs, it will be reflected on the remittance advice for those claims where the offset was applied. Since the claims were originally processed, changes in the beneficiary's paid deductible amounts, other changes in editing, and other outstanding overpayments being collected may affect the final amount paid to the provider.
Last updated 11-20-13

Non-Supplier Claims (institutional and professional providers)

Q1: When will the non-supplier provider claims be reprocessed?

A1: For non-supplier provider claims, the affected providers should be receiving the majority of refunds by the middle of December 2013. Appeals are being handled separately and will take longer to resolve. In addition, CMS is still identifying some overpayments for older dates of service that were collected and they may also take longer to resolve. Medicare history will be corrected by April 2014 for these inappropriate denied and cancelled claims. At that time, Medicare will notify the other users of our data, such as secondary insurers. There will not be remittance advices or Medicare summary notices issued for these reprocessed claims. Providers will receive a spreadsheet with the information they will need to reconcile their books within 3 weeks of receiving their refund. Examples of the spreadsheet and the provider letter that will accompany the spreadsheet are available on the CMS website.
Last updated 11-27-13

Q2: When will a provider receive payment for the reprocessed claims?

A2: For non-supplier provider claims, we anticipate the majority of payments will be issued by the middle of December 2013. The MACs will be sending each affected non-supplier provider a spreadsheet with the payment information for each reprocessed claim within 3 weeks of the refund. Examples of the spreadsheet and the provider letter that will accompany the spreadsheet are available on the CMS website.
Last updated 11-27-13

Q3: How will providers be able to identify affected claims that have been reprocessed?

A3: For non-supplier provider claims, the information will be included in a spreadsheet that the MAC will send to the affected providers shortly after the payment is made to the affected providers. The spreadsheet provides claim level details and should be used to assist in identifying the claims reprocessed and amounts paid or refunded on these claims. Non-supplier providers will not receive a remittance advice for the reprocessed claims. Examples of the spreadsheet and the provider letter that will accompany the spreadsheet are available on the CMS website.
Last updated 11-27-13

Q4: As a non-supplier provider, why won't I get a remittance advice?

A4: CMS has committed to getting the refunds to non-supplier providers as quickly as possible. Because of the timing of reprocessing these claims and the complexities of the impacted financial systems, CMS was able to issue faster refunds by suppressing the remittance advices and Medicare Summary Notices for these reprocessed claims.
Last updated 11-27-13

Q5: When will a provider be notified which claims are going to be reprocessed?

A5: For non-supplier providers, there will be no advance notification. The majority of refunds will be made by the middle of December 2013; information about the refunded claims will be included in a spreadsheet being sent to providers from their Medicare Administrative Contractor. Examples of the spreadsheet and the provider letter that will accompany the spreadsheet are available on the CMS website.
Last updated 11-27-13

Q6: What does it indicate if I do not receive a refund?

A6: There are several explanations for not receiving the refund you were expecting. The refund might have been applied to an outstanding overpayment or accelerated/advanced payment. If this is the case, the remittance advice should provide the necessary information. Appeals are being handled through a separate process and refunds will be issued if the original

claim denial was determined to be incorrect. An additional subset of accounts receivable for affected professional provider claims haven't been closed and will be handled separately by the MACs. If none of these situations is applicable, it indicates the overpayment was correctly assessed.
Last updated 11-27-13

Q7: What does it mean if I do not receive a spreadsheet?

A7: If you receive a refund, you should receive a spreadsheet. If you have not received a spreadsheet by the end of December 2013, please notify your MAC provider contact center. If you did not receive a refund, you will not receive a spreadsheet.
Last updated 11-27-13

Q8: What will the spreadsheet that the MAC is sending to me look like?

A8: Here is an example of what an unpopulated spreadsheet looks like. The spreadsheet will provide the claim details that the non-supplier provider needs to understand which claims were identified as being denied or cancelled in error and the amount of the refund. Many of the fields in the spreadsheet reference HIGLAS. HIGLAS stands for Healthcare Integrated General Ledger Accounting System. It is the accounting system that Medicare uses to collect overpayments made to provider, physicians, suppliers, beneficiaries, insurers, employers, and other entities as well as the accounting system that creates payment files that are sent to the Medicare Claim Processing systems to disburse payments owed.
Last updated 11-27-13

Q9: After reprocessing occurs, will the payments made to the affected non-supplier providers match the amounts recouped for the inappropriately denied claims?

A9: The repayment may not exactly match the original payment that was made for the claims. The claim repayment amount or refund is subject to normal CMS business processes. In other words, the refund when processed by CMS may be used to offset or recoup against any outstanding overpayment that may currently exist. If this occurs, it will be reflected on the remittance advice for those claims where the offset was applied. Since the claims were originally processed, changes in the beneficiary's paid deductible amounts, other changes in editing, and other outstanding overpayments being collected may affect the final amount paid to the provider.
Last updated 11-27-13

SECONDARY PAYERS

Q1: Will information about the reprocessed claims be sent to secondary payers, including State Medicaid Agencies?

A1: Yes. Once the claims are reprocessed, information will be shared with the secondary payers, including the State Medicaid Agencies, in many instances. Whether we share such information will depend on whether the secondary payer accepts mass adjustment claims through our Medicare claims crossover process. Not all secondary payers accept mass adjustment claims via the Medicare claims crossover process.
Last updated 11-20-13

Q2: How do I know if the secondary payer handles mass adjustments using this process?

A2: The best way is to ask the secondary payer whether it accepts mass adjustment claims via the Medicare crossover process. Another suggested approach is to review the way the secondary payers that you bill have handled past Medicare mass adjustments situations. That might be a good predictor of whether the claims will be crossed over.
Last updated 11-20-13

Q3: Between December 2013, when the refunds are issued, and April 2014, when the claims history is adjusted, will CMS work with its COBA trading partners to encourage them to accept mass adjustments?

A3: Yes, CMS will encourage all COBA trading partners to accept mass adjustments associated with the incarcerated beneficiary issue. However, we cannot guarantee that trading partners will amend their crossover agreements with Medicare to accept mass adjustment claims via our COBA crossover process if they historically have not accepted such claims.
Last updated 11-27-13

Q4: If a secondary payer does not accept mass adjustment claims via the Medicare claims crossover process and I am a non-supplier provider, what information should I provide the secondary payer about the claim corrections?

A4: Usually the secondary payer requires a remittance advice. Because non-supplier providers will not be receiving remittance advices for these corrected claims, and Medicare Summary Notices will also not be issued, the provider must work with the secondary payer to determine what information will be accepted. As a work-around, the secondary payer may want a copy of the spreadsheet with the necessary claim information highlighted.
Last updated 11-27-13

APPEALS

Q1: Can I appeal the denied claim? Who is liable for the denied claim?

A1: Yes, providers, suppliers, and beneficiaries can appeal the denied claims. Liability for the denied claims will be determined for each claim on a case by case basis.
Last updated 11-20-13

Q2: Once CMS reprocesses the inappropriate claim denials/cancellations, will there be a way for providers to appeal denied claims that were deemed appropriate even if the time limits for filing appeals expired?

A2: The Medicare Administrative Contractors have been instructed to accept appeal requests for claim denials or overpayments related to incarcerated beneficiaries without regard to the time limits for filing appeals.
Last updated 11-27-13

RECOUPMENTS

Q1: Do suppliers and providers need to take any steps to be repaid for incorrect recoupments resulting from this issue?

A1: Supplier claims will be reprocessed and refunds issued by the end of the first week of December 2013. The majority of non-supplier provider claim refunds will be made by the middle of December. *Last updated 11-27-13*

Q2: Will Medicare repay the recoupments with interest?

A2: The Medicare statute only permits CMS to pay interest under limited circumstances, and this situation does not trigger the payment of interest to providers and suppliers.
Last updated 11-27-13

Q3: What happens to corrections of recoupments that occur after a new MAC has taken over a jurisdiction?

A3: All claims and accounts receivables have been transferred to the incoming MAC.
Last updated 11-20-13

Q4: If a provider or supplier paid interest on one of the collected overpayments, will the repayment of that claim include the amount of interest the provider or supplier paid?

A4: Yes, the provider or supplier will receive a refund for the amount paid including any interest paid.

Last updated 11-20-13

Q5: I continue to receive demand letters and the MAC continues to recoup money for an incarcerated beneficiary related overpayment. What should I do?

A5: While CMS previously zeroed out most of the incarcerated beneficiary overpayments, due to changes in our records over the years, we are still working to identify, zero out, and process refunds for some of the erroneous overpayments. If you are aware of an incarcerated beneficiary overpayment that is still being collected, you should bring it to the attention of your MAC as soon as possible.
Last updated 11-20-13

AVAILABLE AUTOMATED INFORMATION

Q1: How can providers access automated information about a beneficiary's period of incarceration?

A1: The CMS automated systems do not provide specific information about a beneficiary's incarceration status. When a provider makes a 270/271 eligibility query in the HIPAA Eligibility Transaction System (HETS), if the response indicates that the beneficiary is in an inactive status, it is an indication that the beneficiary may be incarcerated. The response does provide the dates for the period of inactivity. The HETS response does not provide information specifying the reason for the period of ineligibility.

This same information is available through the MAC interactive voice response units and provider internet portals.

If a provider calls the MAC's provider contact center, the agents will tell the provider if the Social Security records indicate that this patient was in custody when the service was rendered and that Medicare does not cover items and services furnished to an individual while they are in state or local custody under a penal authority.
Last updated 7-31-13

BENEFICIARY INFORMATION

Q1: How are beneficiaries being notified about the recent incarceration data issues?

A1: CMS mailed a letter to all affected beneficiaries in November that explains the policy and the periods of time during which claims were impacted.
Last updated 11-20-13

Q2: Will beneficiaries receive refunds for beneficiary-submitted claims that were erroneously denied?

A2: Yes. If the claim was denied incorrectly and the beneficiary paid the demand, CMS will send the refund directly to the beneficiary.
Last updated 11-20-13

Q3: Why won't I get a Medicare Summary Notice when the claims for the services I received from non-supplier providers are reprocessed?

A3: Unfortunately, because of the complexities of the impacted systems, CMS had to suppress Medicare Summary Notices for these reprocessed claims. Providers will receive additional information to assist them with accounting. If a beneficiary has a question regarding a reprocessed claim, he or she should contact the provider's office for more information.
Last updated 11-27-13

CREDIT BALANCE REPORTING

Q1: Are providers required to report any duplicate payments they may have received after CMS completed its reprocessing of the inappropriately denied/cancelled claims related to the incorrect editing for incarcerated beneficiaries in the summer of 2013?

A1: Yes. If a provider realizes that it has received a duplicate payment, it should immediately return the overpayment to the MAC that processed the claim. Providers and suppliers are responsible to return any duplicate payments they receive.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare by institutional providers. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. One example of Medicare credit balances include instances where a provider is paid twice for the same service either by Medicare or by Medicare and another insurer.

The CMS-838 can be found online at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS838.pdf
Last updated 11-27-13

OTHER

Q1: When Medicare doesn't pay for the medical services of beneficiaries who are in custody under a penal statute or rule, is the beneficiary responsible for payment?

A1: In most cases, the penal authority will be responsible for payment. Therefore, the provider should bill the penal authority for the care. In the rare cases that the penal authority

is not required to pay for the care, providers can bill Medicare appending a -QJ modifier to the claim (for information, refer to Medicare Learning Network's recent "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet (ICD 908084)).
Last updated 11-20-13

Q2: How frequently is CWF updated with the incarceration data?

A2: Monthly, usually toward the end of the month or the very beginning of a month.
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