



MLN Matters®



Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3866

MLN Matters Number: MM3866

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Related CR Transmittal #: 555

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

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

Note: This article was updated on March 28, 2013, to reflect current Web addresses. All other information remains unchanged

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs)

Provider Action Needed

This instruction is informational for providers so they will be aware of corrections that Medicare FIs will make generating remittance advice notices.

Background

Currently, FIs report add-on-payment(s) such as new technology as additional payments, in the Claim/Service Adjustment Segments (CAS) of Medicare remittance advice transactions when the additional payment is already included in the allowed amount. This results in the double counting of those amounts and creates an out-of-balance situation usually corrected by forcing the balance with an offsetting entry in the same amount with code A7 (presumptive payment adjustment).

This instruction clarifies how Medicare FIs should report add-on-payments on a remittance advice to avoid an out-of-balance situation.

Effective October 1, 2005, FIs must report add-on-payments that do not result in payment of a supplement in addition to the reported allowed amount, in the appropriate claim or service level **AMT segment**, not in a CAS segment. Data reported in any AMT segment is excluded from remittance advice balancing calculations.

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Add-on payments are “Internal” adjustments, actions that factor into the adjudication of a claim. These adjustments 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, but they may affect:

- The reported allowed amount; or
- The payment issued to the provider for the claims reported upon in a remittance advice.

“Internal” adjustments (which the Medicare’s Fiscal Intermediary Shared System (FISS) includes in the allowed amount) currently include the items listed below. (FISS is the system Medicare uses to process claims submitted to FIs.) The Centers for Medicare & Medicaid (CMS) now requires FIs to show the add-on-payments in the appropriate AMT segment according to the following guidelines:

- Inpatient cost outlier - qualifier ZZ
- Hemophilia - qualifier ZK
- New technology, and electroconvulsive therapy supplements - qualifier ZL

FISS will ensure that these amounts are not entered in the CAS segment and are not included in the balancing calculation.

Additional Information

The wording in Medicare Claims Processing Manual, Chapter 22, Section 20 has now been revised to clarify the X12 835 implementation guide expectations and the CMS requirement for the reporting of these “internal” adjustments. That revision is attached to the official instruction (CR 3866) issued to your FI regarding this change. CR 3866 may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R555CP.pdf> on the CMS website.

For additional information relating to this issue, please refer to your local FI. Find the toll free phone number for your local FI at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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