

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program's (NCPDP) version D.0 standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. CMS also encourages you to stay current on 5010/D.0 news and helpful tools by visiting <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html> on its website. **Test early, Test often!**

MLN Matters® Number: MM6870 **Revised**

Related Change Request (CR) #: 6870

Related CR Release Date: June 9, 2011

Effective Date: July 1, 2010

Related CR Transmittal #: R906OTN

Implementation Date: July 6, 2010, except July 5, 2011, for claims processed by the FISS system used by FIs and A/B MACs

Reporting of Recoupment for Overpayment on the Remittance Advice (RA)

Note: This article was updated on November 30, 2012, to reflect current Web addresses. This article was previously revised to add a reference to MM7688 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7688.pdf>) for information on the new standard immediate recoupment process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full by the 30th day from the initial demand letter. All other information is the same.

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative

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Contractors (A/B MACs)) for services provided to Medicare beneficiaries. (CR6870 does not apply to suppliers billing Durable Medical Equipment (DME) MACs.)

Provider Action Needed

This article is based on Change Request (CR) 6870 which instructs Medicare System Maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC Program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You can review Section 1893 http://www.ssa.gov/OP_Home/ssact/title18/1893.htm on the Internet. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the Medicare Learning Network® (MLN) Matters® article related to CR6183 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

Under the scenario just described, the Remittance Advice (RA) has to report the actual recoupment in two steps:

- **Step I:** Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here);
- **Step II:** Report the actual recoupment.

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Recovered amounts reduce the total payment and are clearly reported in the RA to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR6870 instructs the Medicare System Maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an Internal Control Number (ICN) or Document Control Number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:

Claim Level:

The original payment is taken back and the new payment is established

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II:

Claim Level:

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No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional Information

CMS provides more information including an overview of and recent updates for the RAC program at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html> on the CMS website. You can find the guide “Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers” at http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

The official instruction, CR6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R906OTN.pdf> on the CMS website.

You may also want to review MLN Matters® article MM7068, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7068.pdf> on the CMS website. It instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

You may also want to review MLN Matters® article MM7499, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network->

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[MLN/MLNMattersArticles/downloads/MM7499.pdf](#), which alerts providers that Medicare contractors will be using the Patient Control Number as received on the original claim rather than the HIC number when reporting recovery of an overpayment on the Electronic Remittance Advice. This applies to the 005010A1 version of ASCx12 Transaction 835 only and not to the Standard Paper Remit or the 004010A1 version.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found 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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