MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The list of contract suppliers is now available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html* on the CMS website. Visit this CMS website to view additional information on the Round 1 Rebid.

MLN Matters® Number: MM7068 Revised

Related Change Request (CR) #:7068

Related CR Release Date: November 12, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R812OTN

Implementation Date: April 4, 2011; July 5, 2011 for Institutional providers and DME Suppliers

Note: This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised on August 29, 2011, to add a reference to MLN Matters® article MM7499, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7499.pdf*, to alert 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. All other information remains the same.

Instructions for PLB code reporting on Remittance Advice, a Crosswalk between the HIGLAS PLB codes and ASC X12 Transaction 835 PLB codes, and RAC Recoupment Reporting on Remittance Advice for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed

Change Request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the Remittance Advice

(RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the Accounts Receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit 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 can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173), which amended Title XVIII of the Social Security Act (the Act), has added a new paragraph (f) to §1893 of the Act, the Medicare Integrity Program. 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 (see CR6183 – Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the 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.

In a previous CR (Transmittal 659, CR6870), Medicare Carriers, FIs and A/B MACs were instructed to provide enough detail 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.

CR7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

RAC Recoupment Reporting – DME Claims Only

Step I: Claim Level:

The original claim payment is taken back and the new payment is established (Reversal and Correction).

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)
PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: Health Insurance Claim (HIC) #

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

Step II: Claim Level:

No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)
PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

PLB04 shows the actual amount being recouped

A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created – Step I. This document contains a control number for tracking purpose that is also reported on the RA.

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

Note: CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and Standard Paper Remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.

PLB Code Reporting

The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.

The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group Codes,
- Claim Adjustment Reason Codes (CARCs), and
- Remittance Advice Remark Codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

In Version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes – AH and HM – have been added, and code ZZ has been deleted. The other change in Version 005010 is the way situational field PLB03-2 for reference identification is used.

Field	Version 00401A1	Version 005010
PLB03-1		AH – additional code HM – additional code ZZ – deleted code
PLB03-2	Max: 30 Position 1-2: Medicare intermediaries must enter the applicable Medicare code Position 3-19: Financial control number or the provider level adjustment. number or other pertinent identifier Position 20-30: HIC Number	Max: 50 Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1 No Medicare specific codes.

HIGLAS uses additional PLB codes from the X12 Standard that are not in the Implementation Guide (IG) or Technical Report (TR) 3. Medicare must use only those codes that are included in the IG/TR3 to report on the 835.

HIGLAS PLB Codes and ASC X12 Crosswalk

Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and Non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB Code Mapping is applicable to Version 004010A1 as well as 005010A1.

The PLB codes to report on the 835 and HIGLAS and HIPAA PLB Crosswalk may be found in the attachment in CR 7068.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (Transmittal 812/CR 7068) issued to your Medicare contractor at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R812OTN.pdf*on the CMS website.*

You may also want to review the following MLN Matters® articles:

- *Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf*, and*
- *Reporting of Recoupment for Overpayment on the Remittance Advice (RA) at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6870.pdf *on the CMS website.*

If you have questions, please contact your Medicare contractor 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.