

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



News Flash – The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that the majority of providers respond to the initial demand letter and pay the debt. Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged. If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

MLN Matters® Number: MM7717 **Revised**

Related Change Request (CR) #: CR 7717

Related CR Release Date: January 26, 2012

Effective Date: October 1, 2011

Related CR Transmittal #: R2399CP

Implementation Date: July 2, 2012

Clarification for Skilled Nursing Facility (SNF) and Swing Bed (SB) Part A Billing Updating System Requirements for Assessment Date Reporting and Removal of the Occurrence Code 16 Reporting Requirement

Note: This article was revised on February 2, 2012, to show that, effective with the release of CR7717, the requirement for SNF and SB providers to submit occurrence code 16 to indicate the last day of therapy services is discontinued. All other information is the same.

Provider Types Affected

This article is for hospitals and Skilled Nursing Facilities (SNFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for SNF or Swing Bed (SB) hospital services provided to Medicare beneficiaries.

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Provider Action Needed

This article is based on Change Request (CR) 7717 which discontinues the SNF and SB provider reporting requirement for reporting Occurrence Code 16 and updates instructions for assessment date reporting. CR7717 updates current Medicare system edits to add the following Assessment Indicators (AIs) that only require one Occurrence Code 50 (Assessment date reporting) for an assessment that produces two Health Insurance Prospective Payment System (HIPPS) codes required on the claim: 0A, 0B, 0C, 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 5A, 5B, and 5C.

Background

The Centers for Medicare & Medicaid Services (CMS) developed Assessment Indicators (AI) to identify on a claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the Resource Utilization Group (RUG) that is included on the claim for payment of Medicare SNF services. In addition, AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time.

Change Request (CR) 7717 updates current Medicare system edits and CMS manual sections to add the following Assessment Indicators (AIs) that only require one Occurrence Code 50 (Assessment date reporting) for an assessment that produces two Health Insurance Prospective Payment System (HIPPS) codes required on the claim: 0A, 0B, 0C, 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 5A, 5B, and 5C.

In addition, CR7717 instructs that, effective with the release of CR7717, CMS is discontinuing the requirement for SNF and SB providers to report Occurrence Code 16 to indicate the last day of therapy services. CR7717 updates the "Medicare Claims Processing Manual", Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 30 (Billing SNF PPS Services) to remove this requirement, and the revised Section 30 is included as an attachment to CR7717.

Additional Information

The official instruction, CR7717, issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2399CP.pdf> on the CMS website.

If you have any questions, please contact your FIs or A/B MACs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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