



Flu Shot Reminder

As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends.** Get Your Flu Shot. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf> on the CMS website.

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Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) Eligibility System Issues

Note: This article was updated on August 28, 2012, to reflect current Web addresses. This article was also revised on July 1, 2008, to provide a link to the plan directory that can be used to associate the plan name to the plan number on page 2. All other information remains the same.

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Action Needed

Be aware that Medicare reverses FFS payments when MA enrollments with retroactive dates are processed by Centers for Medicare & Medicaid Services (CMS) systems. Also, know what action to take when there are conflicts in CMS eligibility data.

Background

In some cases, MA enrollments with retroactive dates are processed by CMS systems. The result is that Medicare may pay for the services rendered twice;

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once under fee-for-service and second by the MA payment systems in the monthly capitation rate to the plan.

The FFS contractor reverses the fee-for-service payment, recovers from the provider, and the provider then bills the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the Medicare fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

FFS Claims Paid in Error

Due to CMS beneficiary eligibility system updates, beneficiaries enrolled in MA organizations may be identified as having been inappropriately paid on a fee-for-service basis. FIs, carriers, and A/B MACs will adjust these claims and seek overpayments. Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: 'Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan'.

Whenever CMS reverses fee-for-service payments as a result of confirmed retro-active enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

Information on which plan to contact can be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, providers may view the plan directory at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html> on the CMS website.

The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Eligibility Data Discrepancies: Provider Action

Despite system corrections, there remains a small number (under 1000) of beneficiary eligibility records that have not been updated. CMS is working to correct this. In the interim, if a provider has information from the MA plan that conflicts with information received from an FI, carrier, or A/B MAC in reply to an eligibility inquiry, the provider should call the FI/carrier/MAC provider call center. The call center representative will check Medicare's Common Working File

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System and if the conflict is confirmed the provider will be referred to the CMS Regional Office for resolution.

Additional Information

Your call to the FI, carrier, or A/B MAC is a toll free call and if you do not have their number, you can obtain it 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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