CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 106	**Date: AUGUST 25, 2006**
	Change Request 5105

NOTE: Transmittal 100 dated July 3, 2006 is rescinded and replaced with Transmittal 106, dated August 25, 2006. Section II of the business requirements is being revised to remove the requirements for the FI and RHHI. All other information remains the same.

SUBJECT: Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

I. SUMMARY OF CHANGES: - This instruction manualizes Change Request 2801 that was previously published as a Program Memorandum. It creates §190 of Chapter 3 of Publication 100-06 for manualization of requirement to collect fee-for-service payments during periods when the beneficiary was enrolled in a Medicare Advantage Organization.

NEW / REVISED MATERIAL
EFFECTIVE DATE: October 1, 2003
IMPLEMENTATION DATE: June 26, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N	3/190/Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-06	Transmittal: 106	Date: August 25, 2006	Change Request 5105

NOTE: Transmittal 100 dated July 3, 2006 is rescinded and replaced with Transmittal 106, dated August 25, 2006. Section II of the business requirements is being revised to remove the requirements for the FI and RHHI under BR 5105.9. All other information remains the same.

SUBJECT: Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

I. GENERAL INFORMATION

A. Background: Change Request (CR) 2801, Program Memorandum AB-03-101, was issued July 18, 2003. It was not manualized before October 1, 2004. The purpose of this CR is to ensure that any duplicate payments for services rendered to Medicare Beneficiaries are collected.

B. Policy: The Centers for Medicare and Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. Once the data systems recognize a beneficiary has enrolled in a Medicare Advantage (MA) Organization, the MA receives capitation payments for a beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA Payment systems in the monthly capitation rate to the plan. This CR will ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the contractors for overpayments.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5105.1	Upon receipt of notification that a beneficiary has enrolled previously in a MA Plan, CWF will search claims history for any fee for service claims for which payment has been made with dates of service that fall within the retroactive								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	period of the MA enrollment.									
5105.2	CWF will generate an informational unsolicited response (IUR) back to the contractor that originally processed the claim with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based MA payment rules.								X	
5105.2.1	The CWF IUR will include at a minimum the internal document control number (ICN) or document control number (DCN), the health insurance claim number (HICN).								X	
5105.2.2	CWF will not cancel the original claim, but retain it on the paid claims history file.								X	
5105.3	The shared systems software will read the CWF trailer for each claim and generate an automated or manual adjustment					X	X	X		
5105.4	The contractor shall initiate overpayment recovery procedures to retract the original Part A and Part B payment including sending an adjustment to CWF to cancel or update both CWF and contractor history.	X	X	X	X					DMEMAC
5105.5	Upon receipt of an adjustment for the fee-for-service claim on history, CWF will update the deductible and return the corrected deductible information to the contractor in trailer 11.								X	
5105.6	Carriers are to recover any monies due back to Medicare resulting from these denials by following the standard or (customary) recover process.			X						DMEMAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5105.6.1	Carriers shall use the Group Health Organization (GHO) override code of 1 to allow payment in the event that a denial is reversed upon appeal.			X	X					DMEMAC
5105.7	Intermediaries are to recover any monies due back to Medicare resulting from these denials by following the standard or (customary) recovery process.	X	X							
5105.7.1	Intermediaries shall use override code of 1 in the claim header for adjustments to all inpatient and home health claims that are reversed upon appeal.	X	X							
5105.7.2	Intermediaries shall use a value of "2" in the HMO override field for outpatient denials with an "N" No Pay Code.	X	X							
5105.8	Contractors are to report the following on the remittance advice: At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan on the remittance advice.	X	X	X	X					DMEMAC
5105.8.1	Carriers are to allow the following additional information to be made available to providers via letter (or an alternate method): This beneficiary was enrolled in [*Plan Alpha Numeric ID*], a risked based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS internet at			X	X					DMEMAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage.									
5105.8.2	If a provider asks how to determine the correct MA plan to contact, the Intermediary may respond to the provider that performing an eligibility inquiry or contacting the beneficiary will provide an answer.	X								
5105.9	Contractors should use the following language: 16.57- Medicare Part B does not pay for this item or service since our records show that you were in a Medicare + Choice Plan on this date. Your provider must bill this service to the Medicare + Choice Plan. > >16.57 - La Parte B de Medicare no paga por este artículo >servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Su proveedor debe facturar este servicio a el plan de Medicare + Opción .			X						DMEMAC

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5105.10	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					DMEMAC

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2003 **Implementation Date:** June 26, 2006 **Pre-Implementation Contact(s):** Carol Eaton (410) 786-6165 CWF Issues: Rick Wolfsheimer 410-786-6160 **Post-Implementation Contact(s):** Carol Eaton (410) 786-6165 CWF Issues: Rick Wolfsheimer 410-786-6160 Medicare Contractors: Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents

(Rev. 106, 08-25-06)

190 -- Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

(Rev.106, Issued: 08-25-06, Effective: 10-01-03, Implementation: 06-26-06)

Effective October 1, 2003, Common Working File (CWF) implemented the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based MA Enrollment coding files described in the CWF System Documentation at ***http://cms.csc.com/cwf/****.*

Upon receipt of notification that a beneficiary has previously enrolled in a MA Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive MA enrollment. The CWF compares the period between the MA enrollment start date and the ***date of service*** *of the claims in history. Services that fall within the responsibility of the MA Organizations are identified.*

The CWF generates an Informational Unsolicited Response (IUR) with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based MA payment rules. The IUR has all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the Health Insurance Claim number. The CWF electronically transmits the IUR to the contractor that originally processed the claim. The IUR is included in the existing CWF response file. The IURs in that file for claims to be adjusted are identified with a unique transaction identifier. The previously submitted claim is not canceled and will remain on the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the IUR the ***Shared System*** *software reads the trailer for* ***each claim*** *and either a manual or automated adjustment is performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.*

Carriers

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the carrier in trailer 11. Carriers are to recover any monies due back to Medicare resulting from these denials, by following the standard or (customary) recovery process. Carriers are also responsible for providing the M/A plan number to the providers in their correspondence.

In the event that a denial is reversed upon appeal, for carrier claims, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Fiscal Intermediaries (FIs)

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the intermediary in trailer 11. To recover any monies due back to Medicare resulting from these denials, claims are to be adjusted and overpayments are to be recovered through the customary recovery process.

In the event that a denial is reversed upon appeal, a 1 byte override code field is created at the header level for FI claims. The FIs should use override code "1" in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the HMO override field. The purpose of using "1" or "2" is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a MA, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an alternate method).

Language for Carriers to Use in Letter to Provider

Carriers

This beneficiary was enrolled in [Plan Alpha Numeric ID]; a risked based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS internet at ***http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage.***

Fiscal Intermediaries

The plan number is not required on intermediary communications. Those providers are to determine which plan to contact through an eligibility inquiry or by contacting the beneficiary directly.

New Medicare Summary Notice (MSN)

The MSN code *16.57 - Medicare Part B does not pay for this item or service since our records show that you were in an Medicare + Choice Plan on this date. Your provider must bill this service to the Medicare + Choice Plan.*

16.57 - La Parte B de Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Suproveedor debe facturar este servicio a el plan de Medicare + Opción.