CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1099	**Date: June 28, 2012**
	Change Request 7499

Transmittal 1088, dated May 10, 2012 is being rescinded and replaced by Transmittal 1099 for VMS to add the Financial Control Number (FCN) in PLB03-2. All other information remains the same.

SUBJECT: Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number

Effective Date: January 1, 2012

Implementation Date:			
	January 3, 2012:	**Analysis and Design**	**FISS, MCS, VMS**
	January 3, 2012:	**Full Implementation**	**MCS**
	April 2, 2012:	**Full Implementation**	**FISS**
	July 2, 2012:	**Coding**	**VMS**
	October 1, 2012:	**Full Implementation**	**VMS**

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/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) changed reporting of recoupment for overpayment on the Remittance Advice (RA) as a response to provider request per Change Request (CR) 6870 for Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS and 7068 for VIPS - Viable Information Processing Systems. It has been brought to CMS's attention that providing the Patient Control Number as received on the original claim rather than the Medicare Health Insurance Claim Number (HICN or HIC Number) would enhance provider ability to automate payment posting. This would also reduce the need for additional communication via telephone call that would reduce cost for providers as well as Medicare. This CR instructs FISS, MCS and VIPs to replace the HIC number being sent on the RA with the Patient Control Number received on the original claim, if available. This CR also updates requirements as instructed in CR 7268 (935 Limitation on Recoupment- Duplicate payment after Favorable decision for HIGLAS Users) to coincide with these changes. **These changes apply to 835 version 5010A1 only and do not apply to 835 version 4010A1 or Standard Paper Remit (SPR).**

RA has to report the actual recoupment in two steps when there is a time lag between reversal/correction process when overpayment is identified and when Medicare actually recoups the money.

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

Step I: **Claim/Line 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:

1-19: Adjustment Claim Control #

20-39: Patient Control # if available from the original claim

20-39: HIC# if Patient Control # is NOT available

DME 835's will report:

1-14: Financial Control #
15-29: Adjustment Claim Control #
30 – 50: Patient Control Number or HIC # when Patient Control Number is NOT available.

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.

NOTE: Patient Control # could be < or = 20 positions depending on the system capacity

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:

1-19: Adjustment Claim Control #
20-39: Patient Control # if available from the original claim
20-39: HIC# if Patient Control # is NOT available
DME 835's will report:
1-14: Financial Control #
15-29: Adjustment Claim Control #
30 – 50: Patient Control Number or HIC # when Patient Control Number is NOT available.

PLB04 shows the actual amount being recouped

NOTE: Patient Control # could be < or = 20 positions depending on the system capacity

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

B. Policy: CMS generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7499.1	FISS, MCS and VIPs shall complete the Analysis and Design work per the following BRs as applicable to the specific Shared System.						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7499.2	FISS, MCS and VIPs shall continue to report recoupment on ASC X12 Transaction 835 version 005010A1 per previously issued CRs 6870 and 7068 with the following change: Replace HIC # with Patient Control # received on the original (See Step 1 and Step II under General Information) and readjust the positions. If the Patient Control # is not available, send the HIC# in its place.						X	X	X		
7499.3	FISS and MCS shall allow the re-adjusted claim (related to CR 7268) to reflect PLB code J1 on the remittance advice (RA) to include the Patient Control number and Claim Control number.						X	X			
7499.4	FISS and MCS shall ensure the subsequent adjustments (related to CR 7268) correctly reflect PLB code J1 on the remittance advice (RA) to include the Patient Control number and Claim Control number and post to the common working file (CWF).						X	X			
7499.5	VIPs shall update Medicare Remit Easy Print (MREP) software to enable MREP generated ERA to report Patient Control number along with the Claim Control number.								X		
7499.6	FISS shall update PC Print software to enable PC Print generated ERA to report Patient Control number along with the Claim Control number.						X				
7499.7	Contractors shall make necessary translator changes, if needed, to process the updated 835 file received from the shared systems.	X		X	X	X					CEDI
7499.8	VIPs shall add the Financial Control Number (FCN) in front of the Adjustment Claim Control # and report on the ASC X12 Transaction 835 version 005010A1 for both Step I and Step II in CR 7068 – see BR 7499.2. The 50 positions in PLB03 shall contain: • Positions 1-14: Financial Control Number • Positions 15-29: Adjustment Claim Control Number • Positions 30 – 50: Patient Control Number or HIC # when Patient Control Number is not available. Note: The 835 shall report the FCN only until the								X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	DMEMACs transition to HIGLAS										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7499.8	A provider education article related to this instruction will be available at http://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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. 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	X					CEDI

IV. SUPPORTING INFORMATION N/A

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: None

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

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