CMS Manual System

Pub 100-20 One-Time Notification

Transmittal 226

Department of Health & Human Services (DHHS)
Center for Medicare and & Medicaid Services (CMS)
Date: MAY 24, 2006
Change Request 4370

SUBJECT: Allowing Adjustments to Part A and Part B Veterans Administration (VA) Medicare Remittance Advice (MRA) Claims

I. SUMMARY OF CHANGES: This instruction contains information regarding required updates to CWF, FISS and MCS edits.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 2, 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

III. FUNDING:

This project, including this CR, is funded through the IA between CMS and the VA. The VA funds all work on this project.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

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SUBJECT: Allowing Adjustments to Part A and Part B Veterans Administration (VA) Medicare Remittance Advice (MRA) Claims

I. GENERAL INFORMATION

A. Background: In general, claims submitted either contain enough information to process, or don't contain enough information to process.

Claims that do not contain enough information to complete processing are returned to provider (RTP'd). In the Medicare fee for service world, providers are able to access the returned claim, which contains all the previously submitted information. The only action required is to make the necessary corrections, and send the claim back to the Medicare contractor. The VA facilities do not have the ability to access the previously submitted claim. Corrections are made to the VA records, and the claim is resubmitted for processing.

Claims that do contain enough information to process will be either 'processed' or 'rejected'.

Claims are rejected for a variety of reasons. The most common rejections affecting the VA MRA project are due to entitlement, HMO, MSP and duplicates.

Claims that are rejected for entitlement require no further action. The patient does not have Medicare benefits for the type of service rendered. Any disagreement with this rejection requires correction through the Social Security Administration.

Claims that are rejected for HMO require no further action. The patient has elected to access their benefits through a Medicare replacement HMO instead of traditional Medicare. Any disagreement with this rejection requires correction through the HMO indicated on the patient's record.

Claims that are rejected due to Medicare Secondary Payer (MSP) may require additional action. The patient should be contacted by the facility submitting the claim to verify if the information on Medicare's files is correct. These claims, though not 'paid' are considered 'processed'.

If the MSP record on file is incorrect, the facility should have the required corrections made through the COB Contractor. Once the files are corrected to indicate Medicare as the primary payer, the claim must be adjusted.

Claims that are rejected as a duplicate also require follow-up action. The claim history of the patient should be researched to determine what claim is causing the duplicate rejection.

A. If the exact claim was previously submitted and processed, or is still being processed, no action is required.

B. If the services on the claim are additional services rendered on the same day as a previously processed claim, an adjustment must be submitted to add the services to the processed claim.

Claims may also process as partial rejections or partial denials. Claims processed through FISS are processed at a line level, meaning that a claim may be processed but still have some non-covered line items.

Partial rejections are usually due to billing errors on the claim, and adjustments can be submitted to correct the error, such as the addition of a modifier, or the correction to a HCPCS code.

FISS and MCS allow both a cancellation (called a void transaction in MCS) and an adjustment of a previously processed claim.

A cancellation voids the processed claim, any money paid on that claim is recouped, and no further action can be taken on the claim. New claims may be billed at this time without receiving a duplicate edit.

An adjustment on a previously processed claim will cancel, or void the processed claim, and replace it with a new but different claim. Any money paid on the original claim is recouped, and the new claim is paid at the same time. (In MCS, the net amount is paid if appropriate; money is recouped for an overpayment situation.)

A. The VA MRA claims cannot be adjusted in FISS and MCS due to Common Working File (CWF) system restrictions. The system will allow a cancellation of a previously processed claim, but not an adjustment. TrailBlazer is the FI and carrier that processes the VA claims through CMS systems. They have requested CMS assistance correcting this issue by having CWF make system changes to allow adjustments of MRA claims.

B. In addition, MCS is unable to send VA MRA claims as adjustments to CWF, and will need to be modified. Currently, adjusted VA MRA Part B claims from MCS are being sent as original claims.

C. There may be changes needed for FISS, so further analysis is also required.

B. Policy: When a Medicare beneficiary also eligible for veterans health benefits elects to obtain his/her health care at a VA facility, the VA is entitled to collect from the beneficiary's supplemental insurer the deductible and coinsurance that would have been payable had the beneficiary instead received services from a Medicare provider. However, differences in payment methodology between the VA and Medicare make it difficult for the supplemental insurers to calculate the Medicare-equivalent deductible and coinsurance. The CMS is bound by its interagency agreement with the VA to adjudicate these claims on a no pay basis to create a remittance advice notice showing how much Medicare would have paid had the claims been payable by Medicare along with the coinsurance and deductible amounts applicable. As part of this effort, CMS has agreed to accommodate adjustments of VA claims when appropriate.

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	
4370.1	The CWF, MCS, and FISS shall analyze and summarize all changes and system modifications necessary to allow adjustments to Part A and Part B VA claims. This includes a review of all system edits related to Medicare Part A and Part B VA claims.					X	X		X	
4370.1.1	The CWF, MCS, and FISS shall develop procedures and systems to accept, process and finalize adjustments to Part A and Part B VA claims.					X	X		X	
4370.1.2	The CWF shall only allow VA adjustments with dates of service on or after 1/1/2004.								X	
4370.1.3	Consistency edit 0018 shall only be set for VA Part A and Part B adjustments with dates of service prior to 1/1/2004.								X	
4370.1.4	The CWF shall require a Cancel Code as done with regular Part A claims on Cancels. If not present, set consistency edit 0020.								X	
4370.1.5	The CWF shall require an original ICN field to be present as done with regular Part A adjustments.								X	
4370.2	The CWF, MCS, and FISS shall implement all changes and system modifications necessary to allow adjustments to Part A and Part B VA claims.					X	X		X	

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	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: This project, including this CR, is funded through the IA between CMS and the VA. The VA funds all work on this project.

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Stu Barranco at 410-786-6152 for FI issues and Claudette Sikora at 410-786-5618 for Carrier issues **Post-Implementation Contact(s):** Regional Office	**This project, including this CR, is funded through the IA between CMS and the VA. The VA funds all work on this project.**

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