CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 906	**Date: June 9, 2011**
	Change Request 6870

Transmittal 866, dated March 4, 2011 is being rescinded and replaced by Transmittal 906 Dated June 9, 2011. This Change Request (CR) corrects the FISS Implementation Dates for non-935 recoupment as all A MACs will be under HIGLAS in early December, and FISS has already implemented all requirements pertinent to MACs under HIGLAS. All other information remains the same.

SUBJECT: Reporting of Recoupment for Overpayment on the Remittance Advice (RA)

I. SUMMARY OF CHANGES: This Change Request (CR) instructs Fiscal Intermediary Standard System (FISS) and Multi Carrier System (MCS) how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

EFFECTIVE DATE: July 1, 2010
IMPLEMENTATION DATE: MCS: July 6, 2010
FISS: BRs 1-3: July 6, 2010, October 4, 2010
FISS: BRs 1, 4-5: January 3, 2011, July 5, 2011

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; Contractor activities are to be carried out within 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 obligated 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

Pub. 100-20	Transmittal: 906	Date: June 9, 2011	Change Request: 6870

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SUBJECT: Reporting of Recoupment for Overpayment on the Remittance Advice (RA)

Effective Date: July 1, 2010

Implementation Date: MCS**:** July 6, 2010
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I. GENERAL INFORMATION

A. Background: In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007. Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173) amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to §1893 of the Act, the Medicare Integrity Program. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure. Recoupment under the provisions of 935 of the MMA can begin no earlier than the 41st day (see Change Request (CR) 6183,Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the RA has to report the actual recoupment in two steps:

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

It has been brought to our attention that CMS is not providing enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step-by-step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. This CR instructs the Shared System Maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when an overpayment is identified and when Medicare actually recoups the overpayment.

Step I: **Claim 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:

Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

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.

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:

Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped

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

CMS in conjunction with the Shared System Maintainers and the A/B Medicare Administrative Contractors has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

NOTE I: Instructions in this CR apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835.

NOTE II: Any change in Flat File and Companion Document will be issued with the PLB Code Mapping CR scheduled for October

NOTE III: In some very special cases the DCN/HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.

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	
6870.1	FISS and MCS shall follow the Reversal and Correction process as outlined in ASC X12N/005010X221 when overpayment is identified and an A/R is created showing what the provider owes to Medicare. This applies to both 004010 and 5010 versions of 835						X	X			
6870.2	For 935 RAC Recoupment FISS and MCS shall include the detail information as per Step I above in the PLB segment to provide detail information as well as offsetting the recoupment created at the claim level so the net impact on payment would be zero. .						X	X			HIGLAS
6870.3	For 935 RAC Recoupment FISS and MCS shall provide the same detail information at the PLB segment as per Step II above when the actual recoupment happens. **NOTE**: There is no claim level reporting at Step II so that the net impact on payment would be a reduction by the recoupment amount reported in the PLB segment.						X	X			HIGLAS
6870.4	For non-935 RAC Recoupment FISS and MCS shall include the detail information as per Step I above in the PLB segment to provide detailed information as well as offsetting the recoupment created at the claim level so the net impact on payment would be zero.						X	X			HIGLAS

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	
6870.5	For non-935 RAC Recoupment FISS and MCS shall provide the same detail information at the PLB segment as per Step II above when the actual recoupment happens. **NOTE**: There is no claim level reporting at Step II so that the net impact on payment would be a reduction by the recoupment amount reported in the PLB segment.						X	X			HIGLAS
6870.6	MCS shall update Standard Paper Remit (SPR) to reflect the changes being made in the Electronic Remittance Advice per this CR starting in July, 2010.							X			
6870.7	A/B MACs, FIs and RHHIs shall make necessary translator changes, if needed, to process the updated flat file received from FISS. (Updated Part A flat file would be available through eChimp)	X		X		X					

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	
6870.8	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	X		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	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
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 Technical Representative (COTR) 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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