Cost Plan Policy Issue
03-010

Question

Will CMS allow cost plans and HCPPs 100%reimbursement for costs associated with Medicare duplicate claims detection?

Answer

(Note: This policy was issued to all cost plans and HCPPs in a memorandum on September 22, 2003).

After due consideration and in reliance on 42 CFR 417.550(b)(3), CMS will consider requests for full reimbursement from all qualified Medicare cost plans and Health Care Prepayment Plans (the Plans) for the reasonable costs incurred for Medicare duplicate claims detection. The attached document provides detailed requirements and documentation that plans will need to provide to CMS to qualify for consideration for full reimbursement related to Medicare duplicate claims detection. Medicare Plans will be notified by CMS after requests have been evaluated as to whether or not a specific Plan qualifies for full reimbursement for this activity. Among other things, CMS will evaluate the reasonableness of the claimed costs and Plan efficiency (including automation) in conducting this activity.

Please note that Plans have only until December 1, 2003, to submit a request and appropriate documentation to request full reimbursement for duplicate claims detection for contract years 2003 and 2004. After December 1, 2003, Plans that want to first request full reimbursement for activities under 42 CFR 417.550(b) will need to follow the normal prior approval requirements in 42 CFR 417.550(c). These normal prior approval requirements include the fact that such requests are sent to CMS prior to or at the time the budget and enrollment forecast described in 42 CFR 417.572(a)(1) is submitted. It should be noted that projected costs for this cost reporting period (and any future cost reporting periods) are subject to further examination and/or audit by CMS and its designees.

Please submit requests and appropriate documentation in hard copy or electronically to both:

Hard Copy: Peter Castellano, Acting Director
Division of Cost Plans, Health Plan Benefit Group
CMS, Mail Stop C3-15-24
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Electronic: pcastellano@cms.hhs.gov

Hard Copy: Frank Szeflinski, Health Insurance Specialist

CMS
1600 Broadway, Suite 700
Denver, Colorado 80202

Electronic: fszeflinski@cms.hhs.gov

Attachment

Duplicate Claims - Requirements for Full Reasonable Cost Reimbursement

Medicare cost plans and Health Care Prepayment plans that wish to be considered by CMS for full reasonable cost reimbursement for duplicate claims detection for contract year 2003 should submit a formal request to Peter Castellano, Acting Director, Division of Cost Plans, no later than December 1, 2003. Plans that wish to receive consideration only for subsequent years should follow the prior approval requirements in 42 CFR 417.550(c). All requests should be signed by an appropriate official (President, Senior VP) and address the following nine items:

1. The nature of the costs for which the Medicare cost plan or Health Care Prepayment Plan (the Plan) will be seeking full reasonable cost reimbursement.

2. The methodology to be utilized by the Plan to ensure that the costs claimed are, in fact, related only to performance of the plan's responsibility to identify duplicate Medicare claims.

3. The documentation that the Plan will be able to provide, upon audit, to substantiate that the costs claimed for duplicate Medicare claim detection were related solely to this activity.

4. The methodology utilized by the Plan to inform providers that a duplicate claim has been detected, the technique used to recover the overpayment, the means of educating providers regarding claims-submission responsibilities, and the action taken when a provider repeatedly submits duplicate claims, including assurances by the Plan that providers that willfully and repeatedly submit duplicate claims will be reported to CMS and the HHS Office of Inspector General.

5. A brief narrative description of the Plan's current duplicate claims detection efforts, including an explanation of what efforts have been made to automate the process and a description of any other efforts the Plan has made (or is making) to enhance the efficiency of its duplicate claims detection process. The Plan should also specify what additional data CMS would need to provide in order for the Plan to automate its duplicate claims detection process.

6. Whether the request for full reasonable cost reimbursement for duplicate Medicare claim detection is for only 2003, or if it also includes future cost-reporting years

and beyond). In future budget forecasts submitted per 42 CFR 417.572(a), the Plan will need to note any changes in its projected costs for this activity.

7. An estimate of the Plan's costs for which it is seeking full reimbursement, expressed as an annual dollar total and as a per member per month value. The Plan should also include the number of FTEs dedicated to Medicare duplicate claims detection, the

average number of claims reviewed each month, and the percentage of claims reviewed that result in a finding that a potential duplicate payment exists.

8. Whether the Plan pays non-contracting providers directly for covered emergent or urgent care services (Emergency-Urgently Needed Services) provided to Medicare enrollees of the plan, or if the Plan asks non-contracting providers to bill the Medicare fee-for-service contractor first and to subsequently bill the Plan for applicable deductibles and coinsurance?

9. If applicable, a description of the method the Plan uses to determine the amount to pay non-contracting providers directly for covered services (Emergency-Urgently Needed Services) provided to **Medicare enrollees of the plan.**