Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-44 Date: July 28, 2000

CHANGE REQUEST 1277

SUBJECT: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) CONTINGENCY PLANS AND INSTRUCTIONS

Background

In the event that there is a delay in the implementation of OPPS, this Program Memorandum (PM) outlines steps that must be taken to ensure that payment to providers for services subject to OPPS continues.

General Information

In order to assure that beneficiaries are accurately charged for coinsurance, HCFA is urging the hospitals and community mental health centers (CMHCs) not to collect Part B deductibles or coinsurance from Medicare beneficiaries beginning August 1, until we notify hospitals in their remittance advices of the coinsurance amount due from individual beneficiaries or other payers for OPPS claims. In this way, we can ensure that most beneficiaries will be charged the generally lower coinsurance amounts due under OPPS when hospital OPPS claims are processed.

Despite this urging, hospitals and CMHCs still have the authority to choose to collect beneficiaries' payments at the time of service. However, HCFA's analysis shows that this practice is not common. If hospitals and CMHCs do collect payment before a claim is processed, they must make adjustments to the coinsurance amounts due under OPPS (including refunds to the beneficiaries, when appropriate) as soon as possible after the claims are processed and remittance advices are received.

When training or talking to your providers about OPPS, continue to urge the hospitals and CMHCs not to collect Part B deductibles or coinsurance until they receive the remittance advice.

Contingency Plans

HCFA has developed two contingency plans that may be invoked in the event that (1) you cannot process OPPS claims by August 18, 2000 (Plan 1); or (2) a provider cannot submit acceptable OPPS claims by August 18, 2000 (Plan 2).

Below are the steps for both Plan 1 and Plan 2 that are to be taken if either (or both) of the contingency plans are invoked.

NOTE: Special payments available under the OPPS Contingency Plan are in the nature of, but are not precisely the same as, accelerated payments which have long been available by regulation (42 CFR 413.64(g)). Accelerated payments are available on an as-needed basis for a provider experiencing financial difficulties due to a delay by its intermediary in making payments or in exceptional situations for a provider experiencing a temporary delay in preparing and submitting bills beyond its normal billing cycle. To be eligible for accelerated payments, the requesting provider must meet conditions in §2412 of the Provider Reimbursement Manual, Part 1 (PRM). Those conditions, in part, require that the provider has experienced a financial difficulty related to Medicare billing.

Special payments pursuant to the OPPS Contingency Plan serve the same general purpose as accelerated payments - making appropriate estimated payments to providers outside normal payment processing procedures because regular payments are significantly delayed due to intermediary or provider claims processing problems. However, due to the unique nature of the national implementation of OPPS, the requirements for special payments pursuant to the OPPS contingency plan, the calculation, the method of disbursement, duration of the payments and the recovery of the payments are not the same as the procedures for accelerated payments in PRM §2412. Some of the procedures listed below have been changed from the procedures discussed in the May 17, 2000 Memorandum to all Fiscal Intermediaries requesting incremental cost estimates necessary in making special payments under the Contingency Plan.

- o HCFA will notify you on **August 14, 2000** if contingency plan 1 is to be invoked.
- o HCFA does not authorize special payments under either plan before August 21, 2000.

Payment for CMHCs will be based on the same parameters as outlined below in Plans 1 and 2. However, the base period used for the calculation will be from January 1 through April 30, 2000. Biweekly payments will be the total payments for that base period, divided by 8 and multiplied by 85 percent. This calculation will be a manual process. Additional instructions will follow detailing the process, letters, controls and reports that will be required for special payments to CMHCs.

PLAN 1 – Medicare Intermediary Systems Failure

1. If you cannot process claims under OPPS by August 18, 2000, inform your providers by August 25, 2000 that you are temporarily unable to process and make payment on OPPS claims and that they may request special payments pursuant to the OPPS Contingency Plan. Attachment 1 is the letter that is to be sent to all providers advising of the opportunity for special payments. **Do not add to or change the content of the letter.**

2. To be eligible for special payments, a provider must submit an **original signed request.** A provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, an original signed paper request must be received before the special payment can be released. The request for special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**. As part of the request, the provider must acknowledge that recovery will be made by withholding 100 percent from Part B payments, that recovery of all payments is to be completed within 90 days from the date that you are operational with OPPS, and that the provider will make a good faith effort to assure that recovery is made within that time frame. The provider must refund the balance of any special payments that cannot be offset against payments within that time frame. However, see below regarding the limited availability of extended repayment plans. Attachment 2 is a letter to be sent to providers for providers to return as their request for special payments. **Do not add to or change the content of the letter.**

3. You may accept a provider's request as soon as August 21, 2000. Special payments cannot be made under Plan 1 for requests received after OPPS claims processing has begun.

4. You may approve special payments under Plan 1 without the approval of your regional office.

5. Determine the payment amount for each provider based on certain outpatient bills paid (net of deductible and coinsurance) for the period from May 1, 1999 through April 30, 2000. To determine the payment amount, divide the total payments for a provider by 26, then multiply by 85 percent. Only include these bill types: 12X, 13X, 14X (with the exception of critical access hospitals, Indian Health Service hospitals, Maryland hospitals and hospitals located in American Samoa, Saipan and Guam), 34X, 75X, 83X and any bill type containing a condition code 07.

6. If the provider was not in the Medicare program for the entire period from May 1, 1999 through April 30, 2000, use the available months. For example, if the provider was in the program from November 1, 1999 through April 30, 2000, divide the payments by 13 and multiply by 85 percent.

7. If the provider was in the Medicare program for less than six full months, divide the total amount paid by the appropriate number of bi-weekly periods and multiply by 50 percent.

8. Do not make payments to a provider that is not currently receiving Medicare payments or would not be receiving payments during the period for which it would be receiving payments under this contingency plan.

9. If a provider is currently under withhold for any reason, such withhold continues to be applied against these bi-weekly payments.

10. A qualifying provider can receive the above determined bi-weekly amount for a maximum of four bi-weekly payments.

11. Payments are to be released within 10 business days after receipt of a provider's initial request, and bi-weekly thereafter until OPPS claims can be processed.

12. As soon as you are able to process OPPS claims, stop the bi-weekly payments.

13. Once you calculate the payment, you will enter the payment into a spreadsheet for all providers. (This spreadsheet will be a utility program developed by FISS and APASS for their individual users.) FISS and APASS will also develop a utility that will read the spreadsheet into the financial systems and populate the accelerated payment screens. This will eliminate the need to re-key the data into the system.

    The FISS and APASS financial systems are already set up to handle and track advance/accelerated payments. Once the payment is made, the withhold screen will be set to begin collection based on a date determined by HCFA at 100 percent withholding. The withhold screen will also determine that the withhold for these payments will be taken against B payments only, with recovery to be completed within 90 days after you are operational with OPPS. FISS and APASS will develop a utility program to accomplish this to eliminate manual input.

    Should additional bi-weekly payments beyond the initial payment be approved**,** you will use the utility program to establish the additional payment amount(s) and to change the effective date of the withhold, if necessary. FISS and APASS will develop a utility program to systematically change the effective date on the withhold to a date when it is expected that the claims will begin processing, so that no withholds will be made against payments made pursuant to this contingency plan.

    Use the cycle reports within the system that provide detail by provider on the amount of the payments and the amounts withheld. Using these reports, you will be able to track the payments and have the appropriate documentation to support the CFO reports.

14. A provider with extenuating circumstances is permitted to request an extended repayment plan for repayment beyond the above noted 90 days. Since the extended repayment plan will be for less than 12 months, you have the authority to approve or deny such requests. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223 and 2224. However, in no case is an extended repayment plan permitted to extend beyond April 1, 2001.

15. Notify your trading partners that receive crossover claims information of your inability to process OPPS claims. Initial notification must occur by August 25, 2000. Attachment 3 is a letter to be sent to all trading partners. **Do not add to or change the content of the letter.** Trading partners will see a significant decrease in outpatient crossover claims volume during the period where OPPS is not operational. When OPPS is operational, notify your trading partners

16. that OPPS claims are being processed and that there will be an increase in the crossover volume on these claim types until backlogs are processed.

17. If you maintain a web site, keep these communication vehicles current with information regarding the status of OPPS claims processing.

PLAN 2 – Provider Billing Failure

1. Once you are able to process claims under OPPS, and have stopped making special payments under Plan 1 (one, two, three or four payments, depending on your situation), notify your providers that if they are unable to submit claims under OPPS, they may request up to four additional special payments under the OPPS Contingency Plan. (A maximum of eight total payments is possible under Plans 1 and 2 combined. However, a provider could receive less (examples: six payments (two under Plan 1 and four under Plan 2) or five payments (three under Plan 1 and two under Plan 2)).) In no case, however, are you to make payments under Plan 2 while you are making payments under Plan 1. Attachment 4 is a letter that is to be sent to all providers advising of the opportunity for special payments. **Do not add to or change the content of the letter**. Attachment 5 is a letter that can be sent to providers for providers to return as their request for special payments. **Do not add to or change the content of the letter.**

2. The calculation under Plan 2 is the same as under Plan 1. Determine the payment amount for each provider based on certain outpatient bills paid (net of deductible and coinsurance) for the period from May 1, 1999 through April 30, 2000. To determine the payment amount, divide the total payments for a provider by 26, then multiply by 85 percent. Only include these bill types: 12X, 13X, 14X (with the exception of critical access hospitals, Indian Health Service hospitals, Maryland hospitals and hospitals located in American Samoa, Saipan and Guam), 34X, 75X, 83X and any bill type containing a condition code 07.

3. If the provider was not in the Medicare program for the entire period from May 1, 1999 through April 30, 2000, use the available months. For example, if the provider was in the program from November 1, 1999 through April 30, 2000, divide the payments by 13 and multiply by 85 percent.

4. If the provider was in the Medicare program for less than six full months, divide the total amount paid by the appropriate number of bi-weekly periods and multiply by 50 percent.

5. Do not make payments to a provider that is not currently receiving Medicare payments or would not be receiving payments during the period for which it would be receiving payments under this contingency plan.

6. If a provider is currently under withhold for any reason, such withhold continues to be applied against these bi-weekly payments.

7. As under Plan 1, to be eligible for payments, a provider must submit an **original signed request.** A provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, an original signed paper request must be received before the special payment can be released. The request for special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**. As part of the request, the provider must acknowledge that recovery will be made by withholding 100 percent from Part B payments, that recovery for each payment is to be completed within 90 days of the payment, and that the provider will make a good faith effort to assure that recovery is made within that time frame. The provider must refund the balance of any special payments that cannot be offset against payments within that 90 days. However, see below regarding the limited availability of extended repayment plans.

8. In addition, under Plan 2, the provider must report to you the exact nature of its OPPS billing problems, that it currently cannot submit bills to receive payment, and the status of its correction of the billing problems.

9. Under Plan 2, a provider initially may request no more than two additional payments. (See paragraph 14 below regarding subsequent requests from a provider.)

10. Under Plan 2, the regional office must approve the bi-weekly payment. Submit your recommendation, typically to the Division of Financial Management (to the Division of Health Plans and Providers in the Kansas City Regional Office), following existing regional office accelerated payment procedures. Regional office turn around typically is not expected to exceed 48 to 72 hours from receipt of your recommendation.

11. If you agree that the provider warrants payments under Plan 2, recommend approval to your regional office for one or two bi-weekly payments, with your reasons. (Some providers may request only one payment; others may request two, of which you may determine that approval of one or both is warranted.) If you do not agree that the provider warrants the payment(s), recommend no payment(s), with your reasons.

12. A provider may later request additional payments (up to four in total), with additional support that it has made significant progress on resolving its OPPS claims processing problems and that it expects to resolve the problems within the next several weeks.

13. If you find that significant progress has been made and believe the provider likely will resolve the problems within the next several weeks, recommend regional office approval of additional payments as appropriate, with your reasons. If not satisfied that significant progress has been made, recommend no additional payments, with your reasons.

14. In any case (on a provider's initial request, or later) in which you recommended and the regional office approved less than the number of payments the provider requested (or in which you recommended approval but the regional office disapproved), the provider may re-request the payments which originally were disapproved, supporting that it has made further progress in resolving its claims problems. If you are satisfied that an additional payment (or payments) is warranted, recommend regional office approval, with your reasons. If not, recommend no additional payment, with your reasons. In no case may more than four payments be made under Plan 2.

15. Once you calculate the payment, you will enter the payment into a spreadsheet for all providers. (This spreadsheet will be a utility program developed by FISS and APASS for their individual users.) FISS and APASS will also develop a utility that will read the spreadsheet into the financial systems and populate the accelerated payment screens. This will eliminate the need to re-key the data into the system.

    The FISS and APASS financial systems are already set up to handle and track advance/accelerated payments. Once the payment is made, the withhold screen will be set to begin collection based upon a predetermined effective date set by you, and agreed on by the RO, at 100 percent withhold. In determining the effective date of the withhold, review all information submitted and set the date based on when the provider has stated that OPPS billing will begin. The withhold screen will also determine that the withhold for these payments will be taken against B payments only**,** with recovery for each payment to be completed within 90 days of the payment. FISS and APASS will develop a utility program to accomplish this to eliminate manual input.

    Should additional payments beyond the initial payment be approved**,** you will use the utility program to establish the additional payment amount(s) and to change within the system the effective date of the withhold. FISS and APASS will develop a utility program to systematically change the effective date on the withhold to a date when it is expected that the claims will begin processing, so that no withholds will be made against payments made pursuant to this contingency plan.

Use the cycle reports within the system that provide detail by provider on the amount of the payments and the amounts withheld. Using these reports, you will be able to track the payments and have the appropriate documentation to support the CFO reports.

16. As under Plan 1, a provider under Plan 2 with extenuating circumstances is permitted to request an extended repayment plan for repayment beyond the above noted 90 days. Since the extended repayment plan will be for less than 12 months, you have the authority to approve or deny such requests. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223 and 2224. However, in no case is an extended repayment plan permitted to extend beyond April 1, 2001.

Reporting Requirements

Following are reporting requirements developed to capture vital information during the OPPS implementation:

The following information will be required from each Fiscal Intermediary on a weekly basis, starting August 21. Reports are due to CCMO staff by noon every Monday.

Provider Notice:
- # of letters sent (baseline data)
- # of requests received (by date)
- # of requests disapproved

An Excel spreadsheet will be developed by HCFA CO and distributed to all FIs through the CCMOs. CCMO staff will forward summary reports to CHPP (Provider Education) and OFM/FSG/DFI (Debt Management).

Payments:
- Retain by Provider:
  - Date each payment sent
  - Amount of each payment

- Summary report, by intermediary, each Monday, beginning August 21:
  - # of payments requested for week ending
  - Total payments

PORS:
- Enter special payment information into PORS within 10 calendar days of releasing payment.

Workload Management

Backlogs may exist even if Plan 1 is not invoked. Backlogs will be worked using first-in/first-out processing. A separate instruction will be released detailing the process to follow.

The *effective date* for this PM is August 1, 2000.
The *implementation date* for this PM is August 14, 2000.
Funding will be provided through the normal budget process.

If you have any questions regarding:
Financial Management, contact Chuck Booth, OFM, (410) 786-2070
Contractor Management, contact Pat Williams, CBS, (410) 786-6139
Payment Policy, contact John Eppinger, CHPP, (410) 786-4518

Attachments
1— Letter to Providers for Plan 1
2— Letter from Providers for Plan 1

3— Letter to Trading Partners
4— Letter to Providers for Plan 2
5—Letter from Providers for Plan 2

Attachment 1

Fiscal Intermediary Letterhead

Date

Dear Medicare Provider,

The Health Care Financing Administration (HCFA) has announced that the effective date of the Outpatient Prospective Payment System (OPPS) is delayed. The OPPS will begin with dates-of-service on August 1, 2000, and not on July 1, 2000, as previously reported. As of August 14, 2000, Medicare Fiscal Intermediaries are not able to properly process OPPS claims.

Working with provider associations, HCFA has developed a contingency plan that allows providers who are experiencing financial difficulties due to the fiscal intermediary's processing problems to receive special payments. Special payments are based on the concept of accelerated payments in the Provider Reimbursement Manual, Part I, §2412. However, due to the unique nature of the delay in the national implementation of OPPS, the requirements for special payments are not the same as the procedures for accelerated payments.

Providers may request up to four biweekly special payments. **An original signed request is always required.** However, a provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, a provider must submit an original signed paper request before the special payment can be released. The request for special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**. The letter must state that financial difficulties have resulted because of the intermediary's inability to make payments and that the provider understands recovery will be made by withholding 100 percent from Part B payments. The letter must also state that the provider acknowledges that recovery of all payments is to be completed within 90 days from the date that OPPS is operational and that the provider will make a good faith effort to assure that recovery is made within that time frame. For providers currently under withhold for any reason, such withholding will continue to be applied against the biweekly payments. A sample special payment request letter is attached. The special payments under this plan will stop as soon as OPPS becomes operational.

Special payments are calculated based on the previous year's Part B outpatient payments to the provider (net of deductible and coinsurance for the period May 1, 1999 through April 30, 2000) divided by 26 and multiplied by 85 percent. For providers who were not in the Medicare program for the entire period from May 1, 1999 through April 30, 2000, the special payment would be calculated using the number of months of participation. For example, if the provider was in the program from November 1, 1999 through April 30, 2000, the payments are divided by 13 and multiplied by 85 percent. If the provider participated in Medicare for less than six months, the total payments to the provider are divided by the appropriate number of months (for example, for 3 months, the number is 6.5) and multiplied by 50 percent.

After OPPS is operational and the special payments recovery begins, providers with extenuating circumstances may request an extended repayment plan beyond the above noted 90 days. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223, and 2224. Extended repayment plans are for less than 12 months, and in no case is an extended repayment plan permitted to extend beyond April 1, 2001.

If you have questions, please contact (insert FI's name, department and phone number). Also, refer to HCFA's web site: http://www.hcfa.gov. Look on the homepage for the link to OPPS information.

Thank you for your patience and cooperation.

Sincerely yours,

Attachment 2

Date

Provider #:

Dear Fiscal Intermediary,

I am writing to request special payments because we are experiencing financial difficulties due to the delay of the Outpatient Prospective Payment System (OPPS) implementation. I understand the special payments will be made during the interim period until OPPS is operational. I understand that the special payments are made biweekly and are calculated based on the previous year's outpatient payments divided by 26 and multiplied by 85 percent (or other calculations specified in the cover letter if a provider participated in the Medicare program for less than 12 months). Under this OPPS Contingency Plan, we may be eligible to receive up to four biweekly payments.

I understand that recovery of these payments will begin as soon as OPPS is operational and must be fully settled within 90 days of the OPPS becoming operational. Recovery will be made by withholding Medicare Outpatient Part B claims at 100 percent until the special payments have been recouped. We will be responsible for the refund of any outstanding special payment balance that could not be withheld from payments during those 90 days. I understand that if the recovery withholding poses a difficulty, I may request an extended repayment plan.

I certify that I am legally authorized to make financial commitments and assume financial obligations on behalf of this provider of care. If you have questions you may contact me at (insert phone number.)

Sincerely yours,

Name and Title of Individual Signing on Behalf of the Medicare Provider

Attachment 3

Fiscal Intermediary Letterhead

Date

Dear Trading Partner:

We are presently unable to properly process Outpatient Prospective Payment System (OPPS) claims. As a result, we are not able to crossover Medicare paid claims data for OPPS claims.

HCFA is working to diagnose and resolve the problems that are preventing OPPS claims from being processed. We expect to correct the situation and resume OPPS crossovers to you within 30 business days. We will notify you in writing when OPPS claims are being processed. As a trading partner, you may experience a significant increase in OPPS crossover receipts when processing starts and we process the backlog of OPPS claims.

Questions regarding this letter may be directed to (Contact Name) at (Direct Phone Number). Also, updated crossover processing status information may be found on our web site at (Contractor's web site address)

Sincerely,

Name and Title

Attachment 4

Fiscal Intermediary Letterhead

Date

Dear Medicare Provider,

As of (insert date), we have begun processing claims under the Outpatient Prospective Payment System (OPPS). If you are unable to submit claims under OPPS, you may submit an original signed request for up to two bi-weekly special payments. A subsequent request may be submitted in writing for a maximum of two additional bi-weekly special payments (a total of four), if you have not yet completed correction of your claim submission problem.

Each request for special payment must be in writing. Each letter must state the exact nature of the OPPS billing problem(s) you are experiencing. Each must also include a description of actions being taken to correct the billing problem(s). In addition, each letter must state that you acknowledge that recovery of all special payments is to be completed within 90 days of the payment and that you will make a good faith effort to assure that recovery is made within that time frame. For providers currently under withhold for any reason, such withholding will continue to be applied against the biweekly payments. Your request will be forwarded to the regional office for approval. A sample special payment request letter is attached. **An original signed request is always required.** However, a provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, a provider must submit an original signed paper request before the special payment can be released. The request for special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**.

Special payments are calculated based on the previous year's Part B outpatient payments to the provider (net of deductible and coinsurance for the period May 1, 1999 through April 30, 2000) divided by 26 and multiplied by 85 percent. For providers who were not in the Medicare program for the entire period from May 1, 1999 through April 30, 2000, the special payment would be calculated using the number of months of participation. For example, if the provider was in the program from November 1, 1999 through April 30, 2000, the payments are divided by 13 and multiplied by 85 percent. If the provider participated in Medicare for less than six months, the total payments to the provider are divided by the appropriate number (for example, for 3 months, the number is 6.5) of biweekly periods and multiplied by 50 percent.

Providers with extenuating circumstances may request an extended repayment plan beyond the above noted 90 days. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223, and 2224. However, in no case is an extended repayment plan permitted to extend beyond April 1, 2001.

If you have questions, please contact (insert FI's name, department and phone number). Also, refer to HCFA's web site: http://www.hcfa.gov. Look on the homepage for the link to OPPS information. Thank you for your patience and cooperation.

Sincerely yours,

Attachment 5

Provider Letterhead

Date

Provider #

Dear Fiscal Intermediary,

I am writing to request (specify one or two, no more than two may be requested at one time) special payments under OPPS Contingency Plan because (state the exact nature of the OPPS billing problem and steps taken to correct the problems). I understand that the special payments are made biweekly and are calculated based on the previous year's payments divided by 26 and multiplied by 85 percent (or other calculations specified in the cover letter if a provider participated in the Medicare program for less than 12 months). I understand that we may receive no more than four special payments under the OPPS Contingency Plan.

I understand that recovery of special payments must be made within 90 days of the payment. Recovery will be made by withholding Medicare Outpatient Part B claims at 100 percent until the special payments have been recouped, or through direct refund if not entitled to an equal or greater amount of payment during that 90 days. I understand that if the recovery withholding poses a difficulty I may request an extended repayment plan.

I certify that I am legally authorized to make financial commitments and assume financial obligations on behalf of this provider of care. If you have questions you may contact me at (insert phone number.)

Sincerely yours,

Name and Title of Individual Signing on Behalf of the Medicare Provider