Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-021 **Date: FEBRUARY 11, 2002**

CHANGE REQUEST 1955

SUBJECT: Common Working File (CWF) Unsolicited Response Edit and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility (SNF) Residents

This PM is directed to carriers. It is informational only for fiscal intermediaries. It mandates no action on their part.

Effective July 1, 2002, CWF will implement the unsolicited response edit based on the same coding files made available for the reject edits in the carrier SNF coding files described in Transmittal AB-01-159, Change Request 1764. Upon receipt of a Part A SNF claim at CWF, CWF will search paid claims history to determine whether any services subject to consolidated billing were incorrectly paid within the dates of the SNF stay by the carrier. CWF will compare the period between the SNF from and through date to the line item service dates of the claims in history. Consolidated services that fall within the SNF claim from and through dates will be identified.

CWF will generate an unsolicited response, with a trailer containing the identifying information regarding the claim subject to consolidated billing and a new trailer containing line item specific information that identifies all the individual services on that claim that fall within the SNF period. The unsolicited response will have all necessary information to identify the claim, including Document Control Number, Health Insurance Claim number, beneficiary name, date of birth, and beneficiary sex. CWF will electronically transmit this unsolicited response to the carrier that originally processed the claim with consolidated services. These unsolicited responses will be included in the existing CWF response file. The unsolicited responses in that file for claims to be adjusted for consolidated billing will be identified with a unique transaction identifier. The previously paid claim will not be canceled and will remain on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the carrier standard system software will read the line item information in the new trailer for each claim and perform an automated adjustment to each claim. Services subject to consolidated billing will be denied at the line level. The adjusted claims will then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. Carriers and DMERCs will return the claims with entry code 5. Both the covered and the non-covered services must be returned to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible will be updated on the beneficiary's file and the corrected deductible information will be returned to the carrier in trailer 09. To recover any monies due back to Medicare resulting from these denials, carriers should follow the criteria in the overpayment recovery instructions in the Medicare Carriers Manual, Part 3, §§7100-7104 and §§7116-7130 for the policy guidelines for furnishing demand letters and granting appeals rights.

In the event that a denial is reversed upon appeal, the same CWF override code that was developed for the rejects in Transmittal AB-01-159, Change Request 1764, must be used to permit payment to be made.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim will be adjusted by the carrier standard system to line item deny all the services on the claim. These fully non-covered claims must be returned to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's national claims history file. Carrier and DMERC systems will employ existing processes for the submission of fully non-covered claims.

Messages to be used with Denials Based on the Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services are subject to consolidated billing and should have been submitted to the SNF for payment.

Remittance Advice

At the service level, report adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor.

At the service level, report new remark code N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. Only the professional component of physician services can be paid separately.

If appropriate, use remark code MA78 – The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.

Medicare Summary Notice (MSN)/Explanation of Medicare Benefits (EOMB)

MSN code 13.9 / EOMB 16.97 - Medicare Part B does not pay for this item or service since our records show that you were in a SNF on this date. Your provider must bill this service to the SNF.

Also, if appropriate, use MSN 34.8/EOMB 16.92 – The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid.

Or, use MSN 34.3/EOMB 16.93 – After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Use this message only when your system cannot plug the dollar amount in MSN 34.8/EOMB 16.92.)

The *effective date* for this Program Memorandum (PM) is July 1, 2002.

The *implementation date* for this PM is July 1, 2002.

Funding is available through the regular budget process for costs required for implementation.

This PM may be discarded after July 1, 2003.

If you have any questions, contact the appropriate regional office.