# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

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

**Transmittal 249** **Date: JULY 23, 2004**

**CHANGE REQUEST 2989**

**I. SUMMARY OF CHANGES:** This change request adds a new Medicare Summary Notice message for claim adjustments.

**NEW/REVISED MATERIAL - EFFECTIVE DATE: January 3, 2005**
***IMPLEMENTATION DATE: January 3, 2005**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:**
**(R = REVISED, N = NEW, D = DELETED)**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| **R** | 21/50.31/Adjustments |
| **R** | 21/90.31/Ajustes |
| | |
| | |
| | |
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***III. FUNDING:**

**These instructions should be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

| | |
|---|---|
| **X** | **Business Requirements** |
| **X** | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Notification** |

***Medicare contractors only**

# Attachment - Business Requirements

| Pub. 100-4 | Transmittal: 249 | Date: July 23, 2004 | Change Request 2989 |
|---|---|---|---|

## I. GENERAL INFORMATION

**A. Background:** Medicare Summary Notices (MSN) have messages that provide detailed information to beneficiaries concerning claims adjustments. Beneficiaries are sometimes notified through a separate mailing that their provider/supplier has been requested to repay Medicare because of a claim adjustment. By using the MSN to provide this knowledge to the beneficiary, we can ensure that the beneficiary is always notified through an effective and understandable vehicle.

**B. Policy:** The business requirements below add a new message which will tell beneficiaries when their provider/supplier has been requested to refund money to Medicare.

**C. Provider Education:** None.

## II. BUSINESS REQUIREMENTS

***"Shall" denotes a mandatory requirement***
***"Should" denotes an optional requirement***

| Req. # | Requirements | Resp. |
|---|---|---|
| 2989.1 | The standard system shall enable the user to place a message on the Medicare Summary Notice (MSN) which states: *"This adjustment has resulted in an overpayment to your provider/supplier. Your provider/supplier has been requested to repay $____ to Medicare. You do not have to pay this amount." (Note: This message shall be used in conjunction with other messages concerning the claim adjustment and/or limitation of liability. This message shall not be used alone.)* | MCS/ VMS |
| 2989.2 | The standard system shall enable the user to place the Spanish equivalent for this new message on the MSN when appropriate. The Spanish equivalent states: *"Este ajuste ha resultado en un pago excesivo a su proveedor/suplidor. Se le ha pedido a su proveedor/suplidor que devuelva $ _____ a Medicare. Usted no tiene que pagar esta cantidad."(Note: This message shall be used in conjunction with other messages concerning the claim adjustment and/or limitation of liability. This message shall not be used alone.)* | MCS/ VMS |
| 2989.3 | The standard system shall number this MSN message 31.18. | MCS/ VMS |
| 2989.4 | The Medicare contractor shall utilize MSN message 31.18 whenever a claim adjustment results in an overpayment to the provider/supplier, a demand letter is generated and the provider is requested to repay the amount to Medicare. | Medicare carrier/ DMERC |

| | | |
|---|---|---|
| 2989.5 | The Medicare contractor shall utilize this MSN message in conjunction with other messages concerning the claim adjustment, the beneficiary's liability and rights, the provider's right to bill or not bill the beneficiary and any other necessary message to provide the beneficiary with the best knowledge concerning the claim adjustment. | Medicare carrier/<br><br>DMERC |

## III. 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: N/A

### E. Dependencies: N/A

### F. Testing Considerations: N/A

## IV. OTHER CHANGES

| Citation | Change |
|---|---|
| N/A | |

## V. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date: January 3, 2005**<br>**Implementation Date: January 3, 2005**<br><br>**Pre-Implementation Contact(s): Connie Leonard at 410-786-0627 for Overpayment Issues and Julie Day at 410-786-6343 for MSN related issues**<br><br>**Post-Implementation Contact(s): Connie Leonard at 410-786-0627 for Overpayment Issues and Julie Day at 410-786-6343 for MSN related issues** | **These instructions should be implemented within your current operating budget.** |

## 50.31 - Adjustments

***(Rev. 249, Issued 07-23-04, Effective: January 3, 2005/Implementation: January 3, 2005)***

**NOTE:** You must print at least one of the messages in this section for all adjusted claims shown on the MSN.

31.1 - This is a correction to a previously processed claim and/or deductible record.

31.2 - A payment adjustment was made based on a telephone review.

31.3 - This notice is being sent to you as the result of a reopening request.

31.4 - This notice is being sent to you as the result of a fair hearing request.

31.5 - If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 - A payment adjustment was made based on a Quality Improvement Organization request.

31.7 - This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 - This claim was adjusted to reflect the correct provider.

31.9 - This claim was adjusted because there was an error in billing.

31.10 - This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.

31.11 - The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.12 - The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($_____). (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.13 - The Medicare paid amount has been reduced by ($_____) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)

31.14 - This payment is the result of an Administrative Law Judge’s decision.

31.15 - An adjustment was made based on a review decision.

31.16 - An adjustment was made based on a reconsideration.

31.17 - This is an internal adjustment.  No action is required on your part.

*31.18 – This adjustment has resulted in an overpayment to your provider/supplier.  Your provider/supplier has been requested to repay $_____ to Medicare. You do not have to pay this amount. (NOTE: This message shall be used in conjunction with other messages concerning the claim adjustment and/or limitation of liability.  This message shall not be used alone.)*

## 90.31 - Ajustes

***(Rev. 249, Issued 07-23-04, Effective: January 3, 2005/Implementation: January 3, 2005)***

31.1 - Esto es una corrección a una reclamación previamente procesada y/o a su deducible.

31.2 - Un pago ajustado fue procesado basado en una revisión telefónica.

31.3 - Esta notificación es enviada a usted como resultado de una petición de reapertura.

31.4 - Esta notificación es enviada a usted como resultado de su petición por una audiencia.

31.5 - Si usted no está de acuerdo con la cantidad aprobada por Medicare y $100 o más están en disputa (menos el deducible y coaseguro), puede solicitar una audiencia. Debe pedir esta audiencia dentro de 6 meses desde la fecha de esta notificación. Para llegar a los $100, puede combinar cantidades de otras reclamaciones que han sido revisadas. También puede presentar evidencia nueva. Favor de llamar al número indicado en la Sección de Servicios al Cliente si necesita información adicional sobre el proceso de la vista.

31.6 - Un pago ajustado fue hecho basado en una petición por la Organización para el Mejoramiento de la Calidad.

31.7 - Esta reclamación fue previamente procesada bajo un número/nombre de Medicare incorrecto. Nuestros archivos han sido corregidos.

31.8 - Esta reclamación fue ajustada para reflejar el proveedor correcto.

31.9 - Esta reclamación fue ajustada debido a un error en facturación.

31.10 - Este es un ajuste a un cargo procesado previamente. Es possible que esta notificación no refleje los cargos originalmente sometidos.

31.11 - La notificación que enviamos previamente indicó que su médico no puede cobrar más de ($_____). Este pago adicional permite que su médico le facture a usted la cantidad completa cargada.

31.12 - La notificación previamente enviada indicó la cantidad que a usted le pueden cobrar por este servicio. Este pago adicional cambió esa cantidad. Su médico no le puede cobrar más de ($_____).

31.13 - La cantidad pagada por Medicare ha sido reducida por ($_____) previamente pagado por esta reclamación.

31.14 - Este pago es el resultado de una decisión de un juez de derecho administrativo.

31.15 - Un adjuste fue hecho basado en una decisión de revisión.

31.16 - Un ajuste fue hecho basado en una reconsideración.

31.17 - Este es un ajuste interno. Usted no necesita hacer nada.

31.18 - *Este ajuste ha resultado en un pago excesivo a su proveedor/suplidor. Se le ha pedido a su proveedor/suplidor que devuelva $ _____ a Medicare. Usted no tiene que pagar esta cantidad.*