Program Memorandum Intermediaries/Carriers

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

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CHANGE REQUEST 1752

SUBJECT: Unsolicited Response and Auto Adjustment of Claims for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration

This Program Memorandum (PM) contains claims processing instructions and the standard systems and Common Working File (CWF) changes required for contractors to retroactively adjust certain claims inappropriately processed as a result of their being involved in the Medicare Participating Centers of Excellence or Provider Partnerships demonstrations.

Specifically, claims which have been processed under traditional (fee for service) Medicare rules but which, subsequently, it is determined, should be covered under either of the demonstrations' global payment rules must be retroactively adjusted and processed on a "no pay" basis. Conversely, claims which are processed under the rules of either demonstration as "no pay" claims must be adjusted and paid under traditional Medicare rules under certain circumstances. This PM outlines the circumstances under which either of these situations may occur and the processes to be followed.

This PM applies only to claims with dates of service on or after January 1, 2002, for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration. Systems should be operational to process claims under these demonstrations as of January 1, 2002, although the implementation at any specific facility for any of the demonstrations might vary. Demonstration contracts will last three years although CMS will have the option to extend them and/or add additional demonstration sites.

IMPLEMENTATION LIMITED TO DEMONSTRATION AREAS

The Medicare Participating Centers of Excellence Demonstration will be targeted to programs in Illinois, Michigan and Ohio. The Provider Partnerships Demonstration, which is currently under development and subject to final approval, will target hospitals in New York and/or Pennsylvania. In addition, selected demonstration sites ***must*** use intermediaries and carriers that operate on the selected standard systems (Fiscal Intermediary Standard System (FISS) for Part A claims and Multi-Carrier System (MCS) for Part B claims). Hospitals and physicians submitting claims to contractors processing on other claims systems will not be eligible for the demonstration and, therefore, changes to those systems will ***not*** be required.

RELATED CHANGE REQUESTS

Detailed instructions for processing claims under these demonstrations are provided in Change Request (CR) 1525 and CR 1849. This change request specifies additional requirements as well as modifications to the prior procedures, where appropriate. If not otherwise specified, all other instructions outlined in CR 1525 and CR 1849 remain in effect.

CR 1711, "Completion of Home Health Prospective Payment System Consolidated Billing Enforcement" outlines similar unsolicited response and auto adjustment processes. In addition, similar requirements for SNF Consolidated Billing will also be outlined in a future CR.

BACKGROUND

CR 1525 provides complete background information on both of these demonstrations. Due to the complexity of the claims processing requirements for these two demonstrations, unsolicited responses and automatic retroactive adjustment of claims was deferred. This PM (CR 1752) now specifies the instructions necessary to put this process in place.

1. Automatic Adjustment of Claims Previously Processed Under Traditional Medicare Rules

The Notice of Admission (NOA) sets up an auxiliary file record in the CWF, which will be referenced during claims processing. On the intermediary side, it triggers a global payment. On the carrier side, the auxiliary file indicates that related Part B services are to be processed as "no pay" claims. Physicians will be required to submit claims even though they will not be paid by the carrier in order to have the record available in the national claims history file for analytic purposes.

In some circumstances, however, a Part B claim will have been processed for payment prior to the NOA being set up in the auxiliary file. In order to avoid duplicate payments (e.g., the physician being paid by Medicare through the carrier and then directly by the hospital), we need to identify these claims, retroactively adjust the carrier's original fee for service payment, and substitute the alternative global payment. The unsolicited response and automatic adjustment process includes (1)a review by CWF of the claims history to determine if any related claims have been paid; (2)CWF sending an unsolicited response to the carrier indicating which services require adjustment; and (3)the automated adjustment of the original payment by the carrier and substitution of the global payment rules. For ease of reference, both processes together may be referred to as “auto adjustment”. With the exception of the initial implementation utility (see section III below), the auto adjustment process is initiated by the CWF when a final hospital bill is received and processed and the discharge date is put on the NOA.

A. Common Working File-

1. After the discharge date is put on the NOA auxiliary record as a result of processing the final hospital bill (thereby effectively ending the NOA period), the CWF must "look back" and check all hospital based physician or other professional claims *at the claim line level* for carrier paid services "related" to the inpatient admission which might have been processed and paid under traditional fee for service rules, but which are included in the global payment. This includes only services provided at a hospital location, i.e., where the place of service on the claim line is “inpatient”, “outpatient” or “emergency room” (place of service code = 21, 22, or 23). Claims from DME suppliers, ambulance providers, etc., will not be part of the demonstration and are processed according to traditional fee for service Medicare rules. As a result, they will not require any auto adjustment.

   Within the types of claims identified above, whether a claim is covered under the demonstration is determined by two factors: date of service and site of service. The CWF must identify only paid claim lines to physicians or other professional providers for hospital based services meeting either of the following conditions:

   - Site of service provider (i.e., hospital) number on the claim is either blank or matches the hospital on the NOA AND date of service is between admission and discharge date (inclusive);

   OR

   - Site of service provider (i.e., hospital) number on claim does not match the hospital on NOA AND date of service is between (but excludes) admission and discharge date.

2. If claim lines meeting either of the above criteria are found, CWF sends an unsolicited response to the carrier processing the original claim. The unsolicited response indicates which services are to be automatically adjusted by the carrier and why (i.e., service should have been covered under the global demonstration payment). For tracking purposes, CWF will flag claim lines to indicate that an unsolicited response has been sent to the carrier.

3. In accordance with normal processing, after the carrier adjusts the claim, CWF shall make sure that deductible information is updated on the beneficiary's file for use in future processing by either the carrier or fiscal intermediary, as appropriate. CWF must also send the adjustment to the National Claims History File.

B. Carrier

1. Upon receipt of the unsolicited response file from CWF, the carrier Standard System software will read the line item information in the new trailer for each claim and perform and automated adjustment to each claim. The claim will then be re-processed as a no pay claim in accordance with the processing rules under the relevant demonstration. This includes, but is not limited to, reporting of no pay demonstration claims to hospitals as specified in CR 1525.

2. As part of the automatic adjustment process, the carrier shall set up a debit account against which future claims from that provider will be "offset". The carrier must follow existing remittance advice "Correction/Reversal" procedures to adjust the fee for service payment and establish the debit. The reversal remittance advice must include new remark code N68 at the claim line level.

> "Prior payment being canceled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you for this claim by the patient or another insurer must be refunded to that payer within 30 days of this notice."

   As with any new code, notify the provider of the code and its meaning prior to initial use of the code in an electronic remittance advice.

3. Claim lines awaiting payment on the payment floor may also be auto adjusted and reprocessed as no pay claims. Although it would be preferable to be able to stop such payments before they are actually mailed out to providers, it is recognized that this may be difficult to do and is not a requirement for auto adjusting. Thus, it is possible that a claim line which has been approved for payment but is "in the payment floor" waiting to be sent out, gets auto adjusted but still, subsequently, gets sent out to the physician only to ultimately be retracted.

   If there are related claim lines identified on the payment floor when the debit account is set up then deduct the amount set up for the account from the payment amount for the claim on the payment floor. Enter reason code "CW", "claim withholding", in the provider payment adjustment segment of the remittance advice followed by the amount being recovered. Enter the Health Insurance Claim Number (HIC#) for the affected claims in the provider adjustment identifier data element. In addition, use new remark code "N68" as noted above.

4. Carriers will notify beneficiaries of claim lines, which have been auto adjusted through the normal monthly Medicare Summary Notice (MSN), or Explanation of Medicare Benefits (EOMB). A special message, MSN # 60.11 must be used to explain the reason for the auto adjusting of the claim.

MSN Message #	MSN Text – English	MSN Text - Spanish
60.11	This payment is being retracted because the services provided are covered under a demonstration project in which the hospital receives payment for all physician and hospital services related to this admission. The provider should seek reimbursement directly from the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer for these services should be returned by the provider.	Este pago está siendo retirado debido a que los servicios proporcionados están cubiertos bajo el proyecto de demostración en que el hospital recibe el pago para todos los servicios médicos y del hospital relacionados a esta admisión. El proveedor debe procurar el reembolso directamente del hospital en donde el cuidado fue proporcionado. Cualquier deducible o coaseguro pagado por usted o su asegurador suplementario para estos servicios debería ser devuelto por su proveedor.

II. Automatic Adjustment of Claims Previously Processed Under Demonstration Rules ("No Pay" Claims)

The presence of an open NOA causes related Part B claims to be processed as "no pay" claims. Under certain circumstances, however, a hospital may submit an NOA but subsequently determine that a beneficiary is not eligible for coverage under the demonstration. The hospital will then submit to the FI a cancellation of the NOA. However, during the time that the NOA was open, some Part B claims may have been submitted and processed under the rules of the demonstration as "no pay" claims. If the NOA is canceled, then these services must be able to be re-processed under the traditional fee for service Part B Medicare program.

A. Hospital

1. It is the hospital's responsibility to submit a cancellation of the NOA to the FI as soon as it becomes aware that a beneficiary will not be eligible for coverage under the demonstration.

B. Common Working File

1. Upon receipt of a cancellation to an NOA, CWF will initiate a "look back" into the claims history records to identify demonstration claims- i.e., Part B physician or other professional claims - which were processed as "no pay" as a result of the NOA being opened. These claims may be identified by the demonstration number on them: "07" for Medicare Participating Centers of Excellence; "08" for Provider Partnerships.

2. If there are any no pay claims identified relating to the canceled NOA, CWF will send an unsolicited response to the carrier originally processing the claim directing the carrier Standard Systems to automatically adjust the claim. For tracking purposes, CWF will flag claim lines to indicate that an unsolicited response has been sent to the carrier.

3. In accordance with normal processing, after the carrier adjusts the claim, CWF will accept the claim records and send them to the national claims history file. In addition, CWF should make sure that deductible information is updated on the beneficiary's file for use in future processing by either the carrier or fiscal intermediary, as appropriate.

C. Carrier

1. The carrier will automatically adjust demonstration claims identified by CWF by reversing the "no pay" process and processing the claim in accordance with traditional Medicare fee for service payment rules. These claims will now be eligible for any edits or other processes applied to traditional Medicare claims.

2. The carrier will remove the demonstration number from the original claim as part of the adjustment process. Once adjusted, these claims will no longer be considered demonstration claims and will not appear as such in the National Claims History File.

3. Physicians will not be required to re-submit claims that are auto adjusted under this situation in order to be paid.

4. The carrier must notify demonstration hospitals of demonstration claims that are auto adjusted on the demonstration reports which are regularly sent to them. Demonstration claims that are auto adjusted and subsequently paid on a fee for service basis must be specially indicated as such to insure that hospitals are aware that these are NO LONGER covered under the demonstration.

III. Initial Implementation Utility

It is anticipated that implementation of CR 1525 and the global payment demonstrations will precede implementation of this change request. As a result, it is likely that there will be outstanding claims which require retroactive auto adjustment as described under sections I and II above. Therefore, a utility function shall be developed and run just prior to implementation of this change request whereby CWF will identify all claims requiring auto adjustment that have been initially processed since implementation of the demonstrations. Unsolicited responses will be sent to the originating carrier for each of these services and the carriers shall automatically adjust this backlog of claims. This utility function shall include identification of claims paid on a fee for service basis which should have been covered under the demonstration (see section I) as well as demonstration claims which are now eligible for traditional Medicare fee for service reimbursement (see section II).

The *effective* date for this PM is April 1, 2002.

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

These instructions should be implemented within your current operating budget. There are no extra funds allowed for processing claims under this demonstration.

This PM may be discarded December 31, 2005 unless otherwise extended.

All contractors should address questions or issues surrounding implementation of these instructions to their regional office contact. The demonstration contact person for this PM is Jody Blatt at (410) 786-6921.