CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 892	**Date: May 6, 2011**
	Change Request 7268

SUBJECT: 935 Limitation on Recoupment – Duplicate Payment after Favorable Appeal Decision for HIGLAS Users

I. SUMMARY OF CHANGES: This change is to eliminate duplicate payments being made in the shared systems. These payments are due to non-recouped debts that are overturned on appeal and another payment is made to the provider causing a double payment.

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: October 3, 2011

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 892	Date: May 6, 2011	Change Request: 7268

SUBJECT: 935 Limitation on Recoupment – Duplicate Payment after Favorable Appeal Decision for HIGLAS Users

Effective Date: October 1, 2011

Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background: When a claim is appealed by a provider under the 935 Limitation on Recoupment rules, recoupment stops at the 1st and 2nd level until a decision is rendered. In the case that a provider wins the appeal, the Healthcare Integrated General Ledger Accounting System (HIGLAS) accounts receivable must be updated to effectuate the appeal decision and any monies that were recouped, principal and/or interest, shall be returned to the provider if there is no other outstanding overpayments. If the provider wins at the Administrative Law Judge (ALJ) or subsequent levels, the 935 interest shall be calculated separately on any involuntary payment(s) applied to the principal balance and be paid to the provider. In some cases, no recoupment may have taken place at the 1st and 2nd level because the provider appealed before recoupment started. In either case, the Medicare Contractor/Medicare Administrative Contractor (MAC) shall perform a claim adjustment of the originally denied claim to reverse either the full or partial denial to show that the services are in fact payable. In addition, there are occurrences where a non-935 Part B claim has been adjudicated due to an appeal reversal of the overpayment determination and there has been partial or no recoupment on a claim.

Currently, when the overpayment has not been fully recouped and the provider wins a favorable decision on an appeal, the Medicare Contractor/MAC does a full claim adjustment which causes a duplicate payment issue within HIGLAS. When the Medicare Contractor/MAC initiates the readjustment to reverse the denial this results in another payment to the provider. This duplicate payment is due to no, or less than full, recoupment on the original denial and repayment on the reversal of the denial.

B. Policy: For the purpose of this CR, the term 're-adjusted claim' represents the adjustment to the initial claim adjustment that setup the accounts receivable. Based on the first level redetermination decision, this re-adjusted claim will correct claims history only. All adjustments occurring after that point are considered 'subsequent adjustments'. These subsequent adjustments could be to correct the claim based on a higher level appeal decision or to deny a separate line on the claim. This change request (CR) does not constitute policy for Publication 100-06, Medicare Financial Management Manual, Chapter 3 - Overpayments and Chapter 4 - Debt Collection. It is one in a series of CRs that are being designed on system enhancements related to overpayments and clarifying some of the changes found in CR 5424.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7268.1	The Medicare Contractor/MAC shall readjust the originally denied claim to reverse the denial to show that the services are in fact payable. This happens when a 935claim is appealed and there is a full or partial reversal in favor of the provider.	X		X	X	X					
7268.2	The Carrier/Part B MAC shall readjust the originally denied claim to reverse the denial to show that the services are in fact payable. This happens when a non-935 Part B claim is appealed and there is a full or partial reversal in favor of the provider.	X			X						
7268.3	The Shared-System Maintainer shall develop a method to prevent the re-adjusted claim from going to HIGLAS. Note: This would not send the claim debit/credit pair to HIGLAS. These						X				

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claims should not go to the pay floor status location PB9996, but they need to finalize to status location PB9997.										
7268.4	The Shared-System Maintainer shall create a new tape-to-tape code that would stop a claim from going to HIGLAS.						X				
7268.4.1	This new tape-to-tape code shall allow the claim to reflect on the remittance advice (RA) and post to the Common Working File (CWF).						X				
7268.5	The Shared-System Maintainer shall allow the re-adjusted claim to reflect PLB code J1 on the remittance advice (RA) to include the HIC and DCN/ICN number.						X	X			
7268.6	The Shared-System Maintainer shall allow this re-adjusted claim to reflect on the Provider Statistical and Reimbursement (PS&R) report.						X				
7268.7	The Shared-System Maintainer shall allow this re-adjusted claim to be posted to the Common Working File (CWF).						X	X			
7268.8	The Medicare Contractor/MAC shall update the HIGLAS accounts receivable to effectuate the appeal decision.	X		X	X	X					
7268.9	The HIGLAS shall allow the appeals effectuation on the accounts receivable to reflect on the Treasury Report on Receivables (TROR) report. The TROR report is in HIGLAS only once a Medicare Contractor/MAC transitions to HIGLAS.	X		X	X	X					HIGLAS
7268.10	The Shared-System Maintainer shall systematically suppress any subsequent adjustments made on the re-adjusted claims from going to HIGLAS on the 837 interface file.						X	X			
7268.11	The Shared-System Maintainer shall ensure the subsequent adjustments correctly reflect PLB code J1 on the remittance advice (RA) to include the HIC and DCN/ICN number and post to the common working file (CWF).						X	X			
7268.12	The Shared-System Maintainer shall ensure the subsequent adjustments correctly reflect on the Provider Statistical and Reimbursement (PS&R) report.						X				
7268.13	The Shared-System Maintainer shall produce daily reports capturing those claims that did not go to HIGLAS on the 837 interface file. The reports shall be in an agreed upon format between the Medicare Contractors/MACs and the Shared-System Maintainer.						X	X			
7268.14	The Medicare Contractor/MAC shall manually create an accounts payable	X		X	X	X					

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	invoice or an accounts receivable transaction in HIGLAS for any subsequent adjustments made on the re-adjusted claim.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Theresa Jones-Carter (410) 786-7482 Theresa.jones-carter@cms.hhs.gov and Monica Potee (410) 786-4297 monica.potee@cms.hhs.gov

Post-Implementation Contact(s): ***Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.***

VI. FUNDING

Section A: For ***Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediary (RHHIs):***

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs)*****:** The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.