

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-20 One-Time Notification</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1101</b>	<b>Date: July 19, 2012</b>
	<b>Change Request 7499</b>

**Transmittal 1099, dated June 28, 2012 is being rescinded and replaced by Transmittal 1101 to correct the duplicate numbering issue for requirement 7499.8. The Provider Education requirement was erroneously numbered the same as another requirement (7499.8). The Provider Education requirement will be re-numbered as 7499.9. All other information remains the same.**

**SUBJECT: Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number**

**Effective Date: January 1, 2012**

<b>Implementation Date: January 3, 2012:</b>	<b>Analysis and Design</b>	<b>FISS, MCS, VMS</b>
<b>January 3, 2012:</b>	<b>Full Implementation</b>	<b>MCS</b>
<b>April 2, 2012:</b>	<b>Full Implementation</b>	<b>FISS</b>
<b>July 2, 2012:</b>	<b>Coding</b>	<b>VMS</b>
<b>October 1, 2012:</b>	<b>Full Implementation</b>	<b>VMS</b>

*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/revise 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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**  
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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:1101	Date: July 19, 2012	Change Request: 7499
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## **I. GENERAL INFORMATION**

**A. Background:** The Centers for Medicare and Medicaid Services (CMS) changed reporting of recoupment for overpayment on the Remittance Advice (RA) as a response to provider request per Change Request (CR) 6870 for Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS and 7068 for VIPS - Viable Information Processing Systems. It has been brought to CMS’s attention that providing the Patient Control Number as received on the original claim rather than the Medicare Health Insurance Claim Number (HICN or HIC Number) would enhance provider ability to automate payment posting. This would also reduce the need for additional communication via telephone call that would reduce cost for providers as well as Medicare. This CR instructs FISS, MCS and VIPs to replace the HIC number being sent on the RA with the Patient Control Number received on the original claim, if available. This CR also updates requirements as instructed in CR 7268 (935 Limitation on Recoupment- Duplicate payment after Favorable decision for HIGLAS Users) to coincide with these changes. **These changes apply to 835 version 5010A1 only and do not apply to 835 version 4010A1 or Standard Paper Remit (SPR).**

RA has to report the actual recoupment in two steps when there is a time lag between reversal/correction process when overpayment is identified and when Medicare actually recoups the money.

**Step I:** Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)

**Step II:** Report the actual recoupment

**Step I:** **Claim/Line Level:**  
The original payment is taken back and the new payment is established

**Provider Level:**  
PLB03-1 – PLB reason code FB (Forward Balance)  
PLB 03-2 shows the detail:

1-19: Adjustment Claim Control #

20-39: Patient Control # if available from the original claim

20-39: HIC# if Patient Control # is NOT available

DME 835's will report:

1-14: Financial Control #

15-29: Adjustment Claim Control #

30 – 50: Patient Control Number or HIC # when Patient Control Number is NOT available.

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

**NOTE:** Patient Control # could be < or = 20 positions depending on the system capacity

**Step II:**

**Claim Level:**

No additional information at this step

**Provider Level:**

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

1-19: Adjustment Claim Control #

20-39: Patient Control # if available from the original claim

20-39: HIC# if Patient Control # is NOT available

DME 835's will report:

1-14: Financial Control #

15-29: Adjustment Claim Control #

30 – 50: Patient Control Number or HIC # when Patient Control Number is NOT available.

PLB04 shows the actual amount being recouped

**NOTE:** Patient Control # could be < or = 20 positions depending on the system capacity

A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created – Step I. This document contains a claim control number for tracking purposes that is also reported on the RA.

**B. Policy:** CMS generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis.

**II. BUSINESS REQUIREMENTS TABLE**

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers			
						F I S S	M C S	V I P S	C W F	
7499.1	FISS, MCS and VIPs shall complete the Analysis and Design work per the following BRs as applicable to the specific Shared System.						X	X	X	



Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	Note: The 835 shall report the FCN only until the DMEMACs transition to HIGLAS										

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
7499.9	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X	X	X	X	X					CEDI

### IV. SUPPORTING INFORMATION N/A

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below: None**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Sumita Sen at [sumita.sen@cms.hhs.gov](mailto:sumita.sen@cms.hhs.gov) or 410-786-5755

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

## VI. FUNDING

**Section A: 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.

**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.