CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 260	**Date: JANUARY 12, 2007**
	Change Request 5424

Subject: Enhance MCS to Avoid Duplicate Payments When a Full Claim Adjustment is Performed. This CR rescinds and fully replaces CR 3878.

I. SUMMARY OF CHANGES: MCS will be enhanced to avoid duplicate payments when a full claim adjustment is performed. CR 3878, which this CR rescinds and fully replaces, required MCS System Maintainers to conduct an analysis on how best to enhance the MCS system, to evaluate alternative approaches, and to identify all required system changes to implement the approach selected. This CR implements the requirements defined during the analysis and design phase.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 260	Date: January 12, 2007	Change Request 5424

SUBJECT: Enhance the Multi Carrier System (MCS) to Avoid Duplicate Payments When a Full Claim Adjustment Is Performed. This CR rescinds and fully replaces CR 3878.

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: In the MCS system, when a claim is adjusted because of an overpayment, an accounts receivable (A/R) is created and a demand letter sent. When a claim is adjusted because of an underpayment, payment is automatically sent to the provider.

If the claim adjustment (that created the overpayment) later turns out to be incorrect, the contractor must adjust the claim again. This could happen for many reasons. The two most common are: problems with the original overpayment identification and an appeal decision favorable to the provider. When the claim adjustment occurs a second time (to allow for correct history) the MCS system will automatically issue payment to the provider. In many cases, this second payment is duplicative. This then requires an offset from the provider to collect the duplicate payment.

MCS currently uses a void and replace strategy for performing adjustments to overpayment adjustments. The MCS System Maintainer, with CMS and the MCS user group, designed full claim adjustment to act as a full claim void and replace in accordance with the collective understanding of the requirements for HIPPA. This design was developed using a process that if an adjustment creates an overpayment, an accounts receivable is created and a subsequent adjustment assumes that the accounts receivable has either been recouped or will be recouped.
Example:

- A claim is processed and $100 is paid to the Provider.
- It is determined that there is an overpayment of $100.
- The claim is adjusted to show the denial (-$100) and an A/R for $100 is created.
- The claim payment total from the 1st adjustment is $0 = $100 - $100.
- The Accounts Receivable has not yet been collected and the Provider appeals.
- The appeal decision is in the Provider's favor.
- A second adjustment is performed to show the claim as paid. (+ $100)
- The 2nd adjustment calculates its payment based on the previous adjustment.
- Since the previous adjustment reads $0.00 (because the claim was denied) the 2nd adjustment calculated a payment of $100 to the Provider.
- The claim payment total from the 2nd adjustment is $100 = $0 + $100
- A $100 check is issued because MCS cannot suppress the check.
- Since the A/R was never collected, the Provider has been paid twice.

Currently, when a full claim adjustment is performed, history is corrected and the corrected claim is sent to Common Working File. The National Claim History data is also updated.

CR 3878, which this CR rescinds and fully replaces, required MCS System Maintainers to conduct an analysis on how best to enhance the MCS system, to evaluate alternative approaches and associated impacts, and to identify all required system changes to implement the approach selected. This phase was completed; a written analysis document was prepared that defined the system changes to be coded in this April 2007 release; and a conformance review held on October 24, 2006. This purpose of this CR is to implement the requirements defined during this analysis and design phase.

B. Policy: The method selected to enhance MCS to avoid duplicate payments must be compatible with HIGLAS functionality. It also should result in cost savings as the current process to adjust a claim, issue the check and take the duplicate payment back by offset is all a manual process by the Medicare contractor.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5424.1	MCS shall have the ability to suppress payment when a full claim adjustment is performed on a previous overpayment adjustment.								X			
5424.2	All MCS reports shall be evaluated and updated as necessary to take this change into account.								X			
5424.3	MCS shall create a daily report to list all suppressed payments.								X			
5424.4	In order to make sure that no actual payment is issued, no additional money is collected from the beneficiary, and the 835 is balanced, the same amount shall be shown in the PLB segment with opposite signs to offset payment and adjustment amounts shown in the CLP and CAS segment respectively for this re-revised claim. Use code J1 for reporting this amount in the PLB segment.								X			
5424.5	Carriers shall use the adjust down transaction on any open A/R on the previous claim.	X			X							
5424.6	The carrier shall generate a manual check if an A/R has recouped more than can be satisfied by the suppressed payment feature.	X			X							
5424.7	MSN message 31.130 shall be used for the suppressed payment amount.	X			X							
5424.8	For the Carriers on HIGLAS, the MCS shared system shall not send the identified suppressed								X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	adjustment transactions on the HIGLAS 837 to HIGLAS.											
5424.8.1	These suppressed adjustment transactions shall be handled as HIGLAS No Pay transactions. There are not any financial functions needed to be performed on these transactions by HIGLAS.								X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. 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.	X			X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5424.4	The Part B 835 Flat File will be updated and posted following the release of this CR on the following Web site: http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

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VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.