Virtual Conference – Medicare Essentials: Claim Finalization, Remittance Advice and Supplemental Payers

10/19/2022

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
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Objectives

- After this session, attendees will be able to
  - Understand how claims process through FISS
  - Determine status of claims submitted to Medicare
  - Know how Medicare pays providers
  - Read and interpret remittance advice reports
  - Identify payers that pay after Medicare processes claims
  - Recognize when Medicare will automatically crossover claims
- Acronyms used in this PPT are defined on the NGS Acronym Search Tool

Agenda

- Medicare Processing Timeframes
- Medicare Payment
- Remittance Advice
- Supplemental Insurers and Crossovers
- Resources and Wrap Up

Medicare Processing Timeframes

Timely Filing

- Medicare claims must be filed no later than 12 months, or one year, after date services were furnished
  - Applies to both initial submissions and adjustment claims
  - IP claims: 12-month period begins with date of discharge
  - OP claims spanning multiple service dates adjudicated for timely filing based on line item date of service

Timely Filing Exceptions

- Only four valid reasons
  - Administrative error
  - Retroactive Medicare entitlement
  - Retroactive entitlement involving Medicaid
  - Retroactive disenrollment from MAO plan
- CMS Internet Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

Payment Floor

- Earliest day after receipt of clean claim that payment may be made
  - Days determined by counting number of days since day claim received (begins day after day of receipt)
  - Does not apply to no-payment claims, RAPs submitted by HHAs, and claims for PIP payments
- Payment floor standards
  - 14th day for HIPAA-compliant EMC claims
  - 29th day for paper claims

What is a Clean Claim?

- Claim does not require investigation or development externally on prepayment basis
- Clean claims must
  - Be filed in timely filing period
  - Pass all edits
  - Not require external development
  - Have all information necessary to adjudicate claim, and all supporting documentation (if required)

FISS DDE Reports

- Providers have access to reports in FISS DDE
  - Reports available
    - 050 – Claims return to Provider
    - 201 – Pend report
    - 702 – ACS appeals received
    - Credit balance report (CMS 838)

Why You Should Check Medicare's Determination on Your Claim

- You want to know if
  - Claim paid and if so did it pay correctly
  - Claim did not pay and why
  - Claim processed even if you were not expecting Medicare payment
  - You need to take any provider action and how long you have to do so
- You do not want to submit duplicate/overlapping claims!

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How to Check Medicare's Determination on Your Claims

- Remittance advice
- Self-service options
  - FISS DDE
    - FISS Inquiries Sub-Menu (01 option from FISS main menu)
  - NGSConnex
    - Select Claims under My Claims tab
  - IVR
    - Choose option two from main menu for claim status

Checking Medicare's Claim Determination in FISS DDE

- When you submit claim to Medicare FFS for processing, claim receives status/location in FISS DDE
- To determine appropriate provider action you must take (if any), you must know
  - Claim's status/location in FISS DDE
  - Assigned reason code(s) by FISS DDE

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Use FISS Inquiries Sub-Menu Options

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MAP1702          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 12/28/15
MXG9282                    INQUIRY MENU                    C201613F 10:59:25

     BENEFICIARY/CWF          10    ZIP CODE FILE           19
     DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY  1A
     CLAIM SUMMARY            12    CLAIM COUNT SUMMARY     56
     REVENUE CODES            13    HOME HEALTH PYMT TOTALS 67
     HCPC CODES               14    ANSI REASON CODES       68
     DX/PROC CODES ICD-9      15    CHECK HISTORY           FI
     ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10    1B
     REASON CODES             17

   ENTER MENU SELECTION: _

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
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Sub-menu Option 12 – Claim Summary

- Use sub-menu option 12 to
  - Verify whether claim submitted
  - Determine status of submitted claim
  - Determine provider action (correct, adjust, cancel)
  - Can help to resolve RTP/rejection reason codes

Common Claim Status/Locations

Status	Location
Payment floor hold (14/30 days depending on claim submission method; do not take action)	P B9996
Processed claim (finalized location)	P B9997
Denied claim	D B9997
Rejected claim	R B9997
RTP claims (provider should work these)	T B9997
Beginning of the system (all claims start here)	S B0100
ADR (awaiting response/medical records)	S B6000/S B6001
Suspense	S XXXXX
Suspense (awaiting response from CWF)	S B9099

Claim Status/Location P B9997

- If claim processed (P B9997)
  - If it was paid, determine if payment correct/appropriate
    - Check for line item denial or rejection
  - If changes needed, submit adjustment claim or cancel claim as appropriate
    - If claim MSP or conditional
      - Do not cancel
      - Adjust via 837I claim (preferred) or hardcopy claim (ASCA waiver is not required) but not in FISS DDE

Claim Status/Location S XXXXX

- If claim suspended (S XXXXX)
  - Wait! Claim actively processing
    - Do not adjust, cancel, correct or resubmit until finalized
  - No provider action needed but
    - You may contact PCC to ask for claim to be RTP
    - You may contact PCC if claim is suspended in same status/location 30 or more days (or 45 or more days for adjustment claims)

Claim Status/Location T B9997

- If claim has Returned To Provider (RTP)
  - Make necessary claim corrections in FISS DDE
  - Hit PF9 key to resubmit

Claim Status/Location R B9997

- If claim rejected (R B9997)
  - No action may be needed; determine by reason code
    - Resubmit claim if not posted to CWF
      - Examples include but not limited to
        - Entitlement (U5210, U5220)
        - MAO plan enrollment (U5233)
        - Duplicates/overlaps (38200, 38032, 38092, 38005, 38031)
    - Adjust claim if posted to CWF
      - Examples include but not limited to:
        - Primary claim rejected for MSP (34XXX)
        - Claim rejected for timely filing

Medicare Payment

Medicare Payment for Hospital Claims

- Once claim in PB9997 status/location, Medicare issues payment to provider
  - CMS Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Sections 30.2.5 and 30.2.14
- All Medicare payments must be made via Electronic Funds Transfer (EFT) to facility's bank
  - CMS Internet-Only Manual Publication 100-08, *Medicare Program Integrity Manual*, Chapter 10

Payment Prohibitions

- Medicare law prohibits paying benefits due provider directly to another person or organization under assignment, power of attorney or any other arrangement
  - Exceptions in certain circumstances
- Third party cannot purchase provider's Medicare receivables
  - Regardless of language in any agreement provider has with third party that providing financing

Electronic Funds Transfer

- Complete the Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588)
  - Agreement must be signed by authorized or delegated official who signed Medicare CMS-855 enrollment application
- If appropriate CMS-855 Medicare enrollment form not on file with MAC, provider must submit one before EFT can be established
- Electronic Funds Transfer – NGSMedicare

Remittance Advice

Remittance Advice

- Notice of payments and adjustments sent to providers by Medicare contractors
  - Provides detail information for individual processed claims
    - Describes why total original charges not paid in full
  - Helps providers identify any additional action needed
- References:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 22, "The Remittance Advice"
  - Understanding Your Remittance Advice Reports

Forms of Remittance Advice

- Institutional Standard Paper Remittance
  - Sent to non-ERA providers automatically
  - Contact PCC if not received within 45 business days
- ERA
  - Transactions must be produced in current HIPAA compliant ASC X12 835 version/5010
  - Can download file up to 45 business days after issue date

PC Print

- Medicare offers proprietary translator software program called PC Print
- Enables providers to view and print
  - Remittance information on all claims included in 835
  - Remittance information for single claim
  - Summary of claims billed for each TOB processed on this ERA
  - Summary of provider payments

Did You Know…?

- When post office returns SPR due to incorrect address, we must:
  - Flag provider as DNF (“Do Not Forward”)
  - Notify Provider Enrollment
  - Cease generating any further payments or SPRs to provider until new address furnished and verified

Remittance Codes

- Represent standardized reason or condition that relates to claim or service
  - Classified as medical and nonmedical
- All codes may not appear on RA at same time
- Make sure you reference most recent version of code lists/sets
  - External Code Lists | X12

Medical Code Sets

- Identify patient encounter procedures, services, supplies, drugs and diagnoses
  - HCPCS Level I and Level II Codes
  - ICD-10-CM
  - CPT Codes
  - Current Dental Terminology (CDT) Codes
  - NDCs
- Code Sets Overview

Nonmedical Code Sets

- Four types of nonmedical codes used to provide claim and reimbursement information
  - CARC
  - RARC
  - Group codes
  - Provider-level adjustment reason codes
- Also called ANSI Reason Codes

ANSI Reason Code Look Up

- Official website - External Code Lists | X12
  - Code sets updated three times per year
- FISS DDE online system
  - INQUIRIES submenu (01)
  - ANSI REASON CODES (68)
    - Provides narrative information for all reason codes (i.e.,group, reason, REF remark and MIA/MOA codes)
  - Reference *FISS DDE Provider Online Manual* for details

Claim Adjustment Reason Codes

- Provides explanation for when MAC pays claim or service line differently than submitted on claim
  - If adjustment to claim or service line, then no CARC
- Adjustment defined as
  - Denied
  - Zero payment
  - Partial or reduced payment
  - Penalty applied
  - Additional or supplemental payment

Examples of CARCs (https://x12.org)

1	**Deductible Amount** *Start: 01/01/1995*
2	**Coinsurance Amount** *Start: 01/01/1995*
3	**Co-payment Amount** *Start: 01/01/1995*
4	**The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 03/01/2020*
5	**The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
6	**The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
7	**The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

Remittance Advice Remark Codes

- RARCs further explain adjustment or relay informational messages that CARC cannot express
- Informational RARCs (starts with "Alert") give general adjudication information
  - Not always associated with CARC when no adjustment

Examples of RARCs (https://x12.org)

01	**Card interchange fee amount** *Start: 10/01/2018*
02	**Advanced or accelerated payment recoupment amount** *Start: 03/01/2019*
03	**Claim transmission fee amount** *Start: 03/01/2019*
04	**Real-time adjudication resulting in a payment that will follow separately.** *Start: 04/11/2019*
05	**Penalty amount withheld due to reports that were not filed** *Start: 04/11/2019*
06	**Penalty amount withheld due to reports that were filed incorrectly** *Start: 04/11/2019*
07	**Non-Internal Revenue Service third-party withholding amount unrelated to a federal payment levy program** *Start: 11/01/2019*
08	**Penalty Withholding for Bankruptcy/Termination** *Start: 11/01/2019*
50	**The amount of the late charge, late claim filing penalty, or Medicare late cost report penalty.** *Start: 07/01/2018*

Group Codes

- Identifies general category of payment adjustment
- Always used in conjunction with CARC to show liability for amounts not covered by Medicare for claim or service

Group Codes

- CO – Contractual obligations
  - Adjustment due to agreement between payer and payee or regulatory requirement
  - Not billed to patient
- PR – Patient responsibility
  - Used when adjustment represents amount can be billed to patient (deductible, coinsurance, noncovered charges)
- OA – Other adjustments
  - Used when no other group code applies to adjustment

Provider-Level Adjustment Reason Codes

- Adjustments MACs make at provider level, instead of specific claim or service line, such as
  - Increase in payment for interest due as result of late payment of claim by Medicare
  - Deduction from payment as result of prior overpayment
  - Increase in payment for any provider incentive plan

Nettings/Offsets Across Organization Affiliations

- Any related providers will have money applied to oldest remaining accounts receivable balance owed to Medicare
- Related providers
  - Affiliated with same TIN across multiple PTANs
    - CMS policy to recoup based on the TIN rather than PTAN regardless of entity that owes debt
  - Conducting business in two different workloads (such as different states) within single organization

Supplemental Insurers and Crossovers

Supplemental Insurers

- Insurance for beneficiary "cost sharing" amounts
  - Part A or Part B deductibles or coinsurance for Medicare-covered items and services
- Includes
  - Former employer health coverage
  - Retiree coverage
  - Private insurance
  - Medigap plans

Supplemental Insurers

- Providers should obtain supplemental insurer information from beneficiary
  - Can utilize NGSConnex for some crossover information
  - May be required to submit claim to supplemental insurer for patient depending on insurer
- If no supplemental insurance, patient responsible for paying cost sharing amount
  - Provider waits for claim to finalize and obtain cost sharing amount due from remittance advice

Medigap Policies

- Health insurance sold by private insurance companies to fill "gaps" in Medicare FFS
  - Beneficiaries enrolled in FFS Medicare Part A and Part B
  - Coinsurance and deductibles
  - Some offer extra benefits not covered by Medicare
- Standardized plans allow beneficiaries to choose based on cost
  - Must clearly be identified as "Medicare Supplement Insurance"

Medigap Policies

- Identified in most states by letters (Plans A – N)
  - Except for Massachusetts, Minnesota, or Wisconsin
- For Medigap assistance
  - Compare Medigap Plans chart
  - Call 800-633-4227 and ask for free copy of the publication "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare"
  - Contact State Health Insurance Assistance Program (SHIP)

QMB Program

- Eligibility category under Medicare Savings Programs for low income Medicare beneficiaries
  - Medicaid coverage of Medicare Part A and Part B premiums and cost sharing
  - Referred to as "dual eligibles"
- Providers who serve QMBs responsible for billing State Medicaid Agency

QMB Program

- Providers prohibited from billing beneficiaries enrolled in QMB program for Medicare cost-sharing
  - Part A or Part B deductibles or coinsurance for Medicare-covered items and services
- Qualified Medicare Beneficiary (QMB) Program

COBA Program

- Standardizes exchange of eligibility and Medicare claims payment information within claims crossover context
- Permits trading partners (other insurers/benefit programs) to
  - Send eligibility information to CMS
  - Receive Medicare claims data for processing supplemental insurance benefits from Benefits Coordination & Recovery Center (BCRC), CMS' national crossover contractor

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Crossovers

- Automatic versus manual crossovers
  - COBA must be in place between BCRC and private insurance company to automatically cross over claims
  - If no agreement, beneficiary required to coordinate secondary or supplemental payment of benefits with any other insurers he/she may have in addition to Medicare
- To determine if specific claim has crossed over, refer to remittance advice

Thank You!

- Questions?

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