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Medicare Policy Regarding Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

Note: This article was revised on July 1, 2008, to provide a link to the plan directory that can be used to associate the plan name to the plan number on page 2. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations

Background

Once a Centers for Medicare & Medicaid Services (CMS) data system recognizes a beneficiary has enrolled in a MA Organization, the MA organization receives capitation payments for the beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA Payment systems in the monthly capitation rate to the plan. Change Request 5105 and MLN Matters 5105 (see <http://www.cms.hhs.gov/MLNmattersArticles/downloads/MM5105.pdf>) describe how CMS ensures that any fee-for-service claims that are approved for payment erroneously are adjusted and overpayments recovered by Medicare carriers and/or FIs.

A variety of CMS systems issues over the past 18 months prompted CMS to recently synchronize Medicare Advantage enrollment and disenrollment information. As a result, providers may have claims that were affected by this synchronization in one of two ways, both of which are addressed below.

Disclaimer

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Scenario 1. Claims Paid in Error

About 386,000 claims for about 100,000 beneficiaries enrolled in MA organizations have been identified as having been paid on a fee-for-service basis by FIs or carriers during this time. FIs and carriers will, over the next 6 months, adjust these claims and seek overpayments.

Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24 which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan". Upon receipt, providers are to contact the MA plan for payment.

Providers who bill carriers:

The carrier will alert you via letter or alternate method of the following:

- The beneficiary was in a MA plan on the date of service;
- You should bill the managed care plan;
- The plan identification number; and
- Where to find the plan name and address associated with the plan number on the CMS internet site.

Providers who bill FIs:

The adjustment will occur automatically, and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, providers may view the plan directory at <http://www.cms.hhs.gov/MCRAAdvPartDEnrolData/PDMCPDO/list.asp#TopOfPage> on the CMS website.

The number that will appear on the contractor notices will begin with 'H'. For the following 11 plans, the alpha prefix is actually an 'R'. A technical correction will be made in CMS systems in October 2006. Prior to October, when using the web page look up tool, make sure to replace the 'H' with an 'R'. The 11 plans are:

- R3175
- R5287
- R5342
- R5553
- R5566
- R5595

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- R5674
- R5826
- R5863
- R5941
- R9943

MA Plans have been notified:

MA plans know that the resynchronization may result in an increase in payment requests from providers who had claims previously paid, but subsequently overturned by fee-for-service FIs and carriers. Whenever CMS reverses fee-for-service payments as a result of confirmed retro-active enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary. The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Scenario 2. Claims Denied in Error

Because CMS has synchronized Medicare Advantage enrollment and disenrollment information, it is possible that fee-for-service claims were previously denied because the beneficiary was incorrectly identified as being a member of an MA plan. If a provider believes past claims have been denied in error due to problems in enrollment and disenrollment information, those claims can now be resubmitted. For any Part B services, the 10% reduction for timely filing will be waived.

Additional Information

For more information regarding the manualization of this policy, see the MLN Matters article at <http://www.cms.hhs.gov/MLNmattersArticles/downloads/MM5105.pdf> on the CMS website.

If you have questions regarding this issue, contact your carrier/FI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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