CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 638 **Date: AUGUST 5, 2005**

CHANGE REQUEST 3957

SUBJECT: New Medicare Summary Notice (MSN) Messages

I. SUMMARY OF CHANGES: The purpose of this change request is to notify Medicare contractors of a new denial message and a revision to an existing message required by Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 3, 2006
IMPLEMENTATION DATE: January 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	21/50.31/Adjustments
R	21/90.31/Ajustes

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 638	Date: August 5, 2005	Change Request 3957

SUBJECT: New Medicare Summary Notices (MSN) Messages

I. GENERAL INFORMATION

A. Background: Redeterminations and reconsiderations are the new first and second level of appeal under Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. This change request notifies Medicare contractors of revisions to the MSN messages to accommodate the new statutory requirements.

B. Policy: The MSN messages are used to communicate essential information to the Medicare beneficiary regarding claims determinations. Medicare contractors should select and use the most appropriate message for each situation to explain the action taken on a service, item, or claim. The purpose of this change request (CR) is to notify Medicare contractors of a revision to an existing message (31.15) and a new denial message (31.19).

31.15 - An adjustment was made based on a redetermination.

31.19 - If you do not agree with the Medicare approved amount(s), you may ask for a reconsideration. You must request a reconsideration within 180 days of the date of receipt of this notice. You may present any new evidence which could affect your decision. Call us at the number in the Customer Service block if you need more information about the reconsideration process.

Spanish Version:

31.15 - Un ajuste fue hecho basado en una redeterminación.

31.19 - Si usted no está de acuerdo con la(s) cantidad(es) aprobada(s) por Medicare, usted puede solicitar una reconsideración. Usted puede pedir una reconsideración dentro de 180 días de la fecha de recibir este aviso. Usted puede presentar cualquier evidencia que pueda ayudar en su decisión. Llámenos al número de Servicio al Cliente si necesita más información acerca del proceso para pedir una reconsideración.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3957.1	Medicare contractors shall use the most appropriate messages as stated in the CR.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 3, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Maria Ramirez on 410-786-1122 **Post-Implementation Contact(s):** Jennifer Frantz on 410-786-9531	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

50.31 – Adjustments

(Rev. 638, Issued: 08-05-05, Effective: 01-03-06, Implementation: 01-03-06)

NOTE: You must print at least one of the messages in this section for all adjusted claims shown on the MSN.

31.1 - This is a correction to a previously processed claim and/or deductible record.

31.2 - A payment adjustment was made based on a telephone review.

31.3 - This notice is being sent to you as the result of a reopening request.

31.4 - This notice is being sent to you as the result of a fair hearing request.

31.5 - If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 - A payment adjustment was made based on a Quality Improvement Organization request.

31.7 - This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 - This claim was adjusted to reflect the correct provider.

31.9 - This claim was adjusted because there was an error in billing.

31.10 - This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.

31.11 - The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged. (**NOTE:** Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.12 - The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($_____). (**NOTE:** Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.13 - The Medicare paid amount has been reduced by ($_____) previously paid for this claim. (**NOTE:** Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)

31.14 - This payment is the result of an Administrative Law Judge's decision.

31.15 - An adjustment was made based on a *redetermination.*

31.16 - An adjustment was made based on a reconsideration.

31.17 - This is an internal adjustment. No action is required on your part.

31.18 – This adjustment has resulted in an overpayment to your provide/supplier. Your provider/supplier has been requested to repay $_____ to Medicare. You do not have to pay this amount. (**NOTE:** This message shall be used in conjunction with other messages concerning the claim adjustment and/or limitation of liability. This message shall not be used alone.

31.19 - If you do not agree with the Medicare approved amount(s), you may ask for a reconsideration. You must request a reconsideration within 180 days of the date of receipt of this notice. You may present any new evidence which could affect your decision. Call us at the number in the Customer Service block if you need more information about the reconsideration process.

Spanish MSN

90.31 – Ajustes

(Rev. 638, Issued: 08-05-05, Effective: 01-03-06, Implementation: 01-03-06)

31.1 - Esto es una corrección a una reclamación previamente procesada y/o a su deducible.

31.2 - Un pago ajustado fue procesado basado en una revisión telefónica.

31.3 - Esta notificación es enviada a usted como resultado de una petición de reapertura.

31.4 - Esta notificación es enviada a usted como resultado de su petición por una audiencia.

31.5 - Si usted no está de acuerdo con la cantidad aprobada por Medicare y $100 o más están en disputa (menos el deducible y coaseguro), puede solicitar una audiencia. Debe pedir esta audiencia dentro de 6 meses desde la fecha de esta notificación. Para llegar a los $100, puede combinar cantidades de otras reclamaciones que han sido revisadas. También puede presentar evidencia nueva. Favor de llamar al número indicado en la Sección de Servicios al Cliente si necesita información adicional sobre el proceso de la vista.

31.6 - Un pago ajustado fue hecho basado en una petición por la Organización para el Mejoramiento de la Calidad.

31.7 - Esta reclamación fue previamente procesada bajo un número/nombre de Medicare incorrecto. Nuestros archivos han sido corregidos.

31.8 - Esta reclamación fue ajustada para reflejar el proveedor correcto.

31.9 - Esta reclamación fue ajustada debido a un error en facturación.

31.10 - Este es un ajuste a un cargo procesado previamente. Es possible que esta notificación no refleje los cargos originalmente sometidos.

31.11 - La notificación que enviamos previamente indicó que su médico no puede cobrar más de ($_____). Este pago adicional permite que su médico le facture a usted la cantidad completa cargada.

31.12 - La notificación previamente enviada indicó la cantidad que a usted le pueden cobrar por este servicio. Este pago adicional cambió esa cantidad. Su médico no le puede cobrar más de ($_____).

31.13 - La cantidad pagada por Medicare ha sido reducida por ($_____) previamente pagado por esta reclamación.

31.14 - Este pago es el resultado de una decisión de un juez de derecho administrativo.

31.15 - Un adjuste fue hecho basado en una *redeterminación*.

31.16 - Un ajuste fue hecho basado en una reconsideración.

31.17 - Este es un ajuste interno. Usted no necesita hacer nada.

31.18 – Este ajuste ha resultado en un pago excesivo a su proveedor/suplidor. Se le ha pedido a su proveedor/suplidor que devuelva $ _____ a Medicare. Usted no tiene que pagar esta cantidad.

31.19 – Si usted no está de acuerdo con la(s) cantidad(es) aprobada(s) por Medicare, usted puede solicitar una reconsideración. Usted puede pedir una reconsideración dentro de 180 días de la fecha de recibir este aviso. Usted puede presentar cualquier evidencia que pueda ayudar en su decisión. Llámenos al número de Servicio al Cliente si necesita más información acerca del proceso para pedir una reconsideración.