Adjustments to claims subject to retroactive payment changes in the first several months of 2010 are scheduled to begin in the near future, according to the following communication from the Centers for Medicare and Medicaid Services. As noted in the announcement, most of the adjustments will be made automatically but in some instances where the submitted bill was lower than the revised payment rate, physicians will need to request an adjustment. The AMA has had multiple discussions with CMS on this issue, including a sign-on letter urging the agency to take timely action and work to make the process as automatic as possible. However, the adjustment process was delayed until legislation to provide contractor funding was enacted and no deadline has been set for completion of the adjustments due to the large volume of claims involved and CMS's desire not to create log-jams in processing of current claims. The AMA will continue to monitor the situation and argue for changes where needed.

From: Medicare information for physicians [mailto:PHYSICIANS-L@LIST.NIH.GOV] **On Behalf Of** CMS CMSProviderResource
Sent: Tuesday, February 08, 2011 12:01 PM
To: PHYSICIANS-L@LIST.NIH.GOV
Subject: Reprocessing Claims Affected by the Affordable Care Act and 2010 Medicare Physician Fee Schedule Changes

Reprocessing Claims Affected by the Affordable Care Act and 2010 Medicare Physician Fee Schedule Changes

This message is for physicians, other practitioners, ambulance suppliers, inpatient/outpatient hospitals, long term care hospitals, inpatient rehabilitation facilities, home health agencies, and any other provider type affected by the post-effective date implementation of select provisions of the Affordable Care Act and the 2010 Medicare physician fee schedule.

On March 23, 2010, President Obama signed into law the Affordable Care Act. Various provisions of the new law were effective April 1, 2010, or earlier and, therefore, were implemented some time after their effective date. In addition, corrections to the 2010 Medicare Physician Fee Schedule (MPFS) were implemented at the same time as the Affordable Care Act revisions to the MPFS, with an effective date retroactive to January 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims will be reprocessed. Given this large workload, the Centers for Medicare & Medicaid Services (CMS) is taking steps to ensure that new claims coming into the Medicare program are processed timely and accurately, even as the retroactive adjustments are being made. CMS ***will begin*** to reprocess these claims over the next several weeks. We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual

reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, we believe that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (http://www.cms.gov/manuals/downloads/clm104c34.pdf). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contactors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a $25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than $10, your contractor will not request repayment until the total amount owed accrues to at least $10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (http://www.cms.gov/manuals/downloads/fin106c04.pdf) for more information.

The CMS wants to remind physicians, practitioners, suppliers, and other providers, impacted by the retroactive increases in payment rates for claims affected by the Affordable Care Act and 2010 MPFS changes, of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. The policy may be found at the following link:

http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf

Please contact your Medicare claims administration contractor with any questions about this information.

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Sent by: American Medical Association * Helping doctors help patients
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