



February 10, 2011

Reprocessing Claims Affected by the Affordable Care Act and 2010 Medicare Physician Fee Schedule Changes
CMS Message 201102-18

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 contractors 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.

NHIC, Corp.

75 Sgt. William Terry Drive
Hingham, MA 02044
www.medicarenhic.com

TMP-EDO-0005 V3.0 Release date: 10/21/10

The controlled version of this document resides on the NHIC Quality Portal (SharePoint). Any other version or copy, either electronic or paper, is uncontrolled and must be destroyed when it has served its purpose.



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.

NHIC, Corp.

75 Sgt. William Terry Drive
Hingham, MA 02044

www.medicarenhic.com

TMP-EDO-0005 V3.0 Release date: 10/21/10

The controlled version of this document resides on the NHIC Quality Portal (SharePoint). Any other version or copy, either electronic or paper, is uncontrolled and must be destroyed when it has served its purpose.



Information for Eligible Professionals about Registration for the Electronic Health Record Incentive Programs

Designation of a third-party to register – At this time, there is no method available for a third-party to register multiple eligible professionals (EPs) for the Medicare and Medicaid EHR Incentive Programs. Beginning in May, CMS plans to implement functionality that will allow an EP to designate a third-party to register and attest on his or her behalf. We will release detailed information about that process when it is available.

Please be aware that, currently, EPs are NOT permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third-parties can place your information at risk. Until CMS implements new functionality in May, each EP should register himself or herself separately for the Medicare and Medicaid EHR Incentive Programs.

Registration for the Medicaid program – Eligible professionals must select between the Medicare and Medicaid EHR Incentive Programs. If you register for the Medicaid EHR Incentive Program, when you select “Medicaid” on the registration screen, you will be asked to select a state from the drop-down menu. Only states with launched programs (ie. states that are prepared to confirm your eligibility and make payments) are listed in that drop-down menu. Each month, CMS will add new states as they launch programs. If you have questions about when your state will launch, visit [Medicaid State Information](#). You may also contact your State Medicaid Agency for more information about the program; visit [State EHR Incentive Program Launch Dates and HIT Websites](#) for the Medicaid EHR Incentive Program links for each State Medicaid Agency.

For more information about the Medicare & Medicaid EHR Incentive Programs and to register, visit <http://www.CMS.gov/EHRIncentivePrograms>.

NHIC, Corp.

75 Sgt. William Terry Drive
Hingham, MA 02044
www.medicarenhic.com

TMP-EDO-0005 V3.0 Release date: 10/21/10

The controlled version of this document resides on the NHIC Quality Portal (SharePoint). Any other version or copy, either electronic or paper, is uncontrolled and must be destroyed when it has served its purpose.