Claims Reprocessing: Questions & Answers for Providers
(NOTE: For these Questions & Answers, the term "provider" is used generically to cover all physicians, other practitioners, suppliers, hospitals, and others affected by the Affordable Care Act and corrections to the 2010 Medicare Physician Fee Schedule.)

#	Question	Answer
1	Why are certain Medicare claims being reprocessed?	The Affordable Care Act includes provisions that impact the payment of Medicare claims. The law was enacted on March 23, 2010; however, various provisions of the Affordable Care Act were effective April 1, 2010, or earlier. Given the time it takes to implement program changes, Medicare must adjust certain already-processed claims with dates of service or dates of discharge on/after the effective date of the change, but before the change was implemented. 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. The retroactive effective dates of the Affordable Care Act provisions (which affect many different provider types, including hospitals, inpatient rehabilitation facilities, ambulance suppliers, and physicians/other practitioners) and the MPFS corrections have resulted in a large volume of Medicare fee-for-service claims needing to be reprocessed.
2	What types of claims are affected by the reprocessing effort? What is the exact span of dates covered by the reprocessing effort?	On or before April 28, 2011, Medicare claims administration contractors will have posted to their Web sites a chart, *Affordable Care Act Provisions Requiring Reprocessing of Medicare Fee-For-Service Claims*. This chart lists the types of claims to be reprocessed, the effective date of the change, and the respective implementation date of the change. There are no unique or specific codes and services affected by claims reprocessing. All codes and services within a provider/claim-type are affected.

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3	Why are we adjusting 2010 claims now? Why are there so many adjustments?	The volume of claims requiring reprocessing is unprecedented. The Centers for Medicare & Medicaid Services (CMS) is adjusting these claims at this point in time because we needed time to develop a reprocessing plan that would not disrupt the normal/regular flow of claims into the Medicare claims processing systems and to obtain the necessary funding. There is a large volume of adjustments because the retroactive nature of some of the changes impacted several months (in some cases) of claims. For example, the 2010 MPFS was effective January 1, 2010, but the Affordable Care Act was enacted March 23, 2010. Plus, CMS and its contractors needed time to develop, test, and implement the Affordable Care Act changes along with the changes resulting from the 2010 MPFS correction notices. The MPFS effort was complete in May 2010 (completion times varied by contractor). Given that Medicare processes about 70 million MPFS claims each month, one can see how the reprocessing claims volume is very large.
4	Do providers have to request that claims be reprocessed or adjusted? Similarly, should providers request reopenings to facilitate or expedite the reprocessing of their claims?	In the majority of cases, providers will not have to request adjustments because the Medicare claims administration contractors will automatically reprocess claims. The exception is any claim that contained services with submitted charges lower than the revised 2010 fee schedule amount for the Medicare Physician Fee Schedule or the Ambulance Fee Schedule. Affected providers who would like the higher rates must contact their Medicare contractor to have their claim's submitted charge increased to, at least, the new payment rate. We recommend that providers not submit requests for redeterminations or reopening for claims that are subject to this reprocessing effort. Automatic reprocessing will allow for a smoother, first in/first out flow of claims and payments. Therefore, providers' remittance advices (RAs) should be more manageable and facilitate easier reconciliation of adjusted claims.
5	Should providers resubmit claims?	No. Providers should not resubmit claims because they may be denied as duplicate claims and slow the retroactive adjustment process.
6	What is the timeframe for the claims to be reprocessed?	The timeframe will vary by claim type, volume and the individual Medicare claims administration contractor. Providers may contact their Medicare contractors about their estimated completion date. CMS is hopeful that most claims reprocessing will be completed within 12 months.

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7	What if the reprocessing or adjustment results in an over-or under-payment?	Medicare claims administration contactors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing claims. • Underpayments will be included in the 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, the Medicare 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.
8	Are providers obligated to refund overpayments to beneficiaries and supplemental payers?	Standard overpayment recovery procedures apply. Providers have an obligation to refund overpayments to beneficiaries. How they go about doing that is up to the provider. For example, some providers may choose to credit the beneficiary's next visit, and some may wait for a certain number of overpayments to accumulate before issuing a refund (if one beneficiary has multiple overpayments). Regardless of how it is done, providers do have an obligation to refund monies owed to beneficiaries. Adjustments are sent to secondary insurers because those insurers have an obligation to pay the cost of certain additional beneficiary obligations, and they too may be entitled to refunds associated with any overpayments. This is the normal procedure. Providers may contact supplemental insurers to ascertain the supplemental insurer's policy regarding provider payments owed to the insurer.

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9	What should a provider do if his/her claims were not adjusted? If the provider receives a remittance advice (RA) for a reprocessed claim and determines that it billed the claim incorrectly, can it still appeal the claim? Can a Provider appeal the overpayment request?	Providers should contact their Medicare contractor with questions about claims that were not adjusted, but that they believe should have been adjusted. Providers should give contractors adequate time to complete adjustments before contacting them on this issue, or before requesting a reopening or filing an appeal request. Providers may request a reopening to fix clerical errors or billing errors. Contractors will process all corrections of clerical errors as reopenings. Alternatively, providers may file an appeal request if they disagree with coverage and/or payment determinations, including overpayment determinations.
10	What is the timeline for an appeal or a request for a reopening? What if the 1-year limit for providers to request a reopening of a claim has passed?	Providers may request a reopening for any reason within 1-year. Additionally, providers may have up to four years to request a reopening if there is "good cause" for requesting the reopening. The "good cause" criteria are described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (http://www.cms.gov/manuals/downloads/clm104c34.pdf). Making changes to the submitted charge as a result of rate increases due to the Affordable Care Act and/or 2010 correction notices is a circumstance that would warrant a determination that good cause exists. Otherwise, all other mandatory time limits for reopenings and appeals are applicable.
11	Can providers determine which adjustments are related to this reprocessing effort by reviewing the remittance advice (RA)? Can providers receive these adjustments on a separate RA?	In some cases, contractors will have these claim adjustments individually identified with a Claim Adjustment Reason Code (CARC)/RA Remark Code (RARC). The Medicare contractors may use a different code(s); therefore, the contractors will inform their providers which CARCs/RARCs to watch for. In an effort to expedite the commencement of claims reprocessing, it was decided to use normal operating procedures. Therefore, reprocessed claims must be a part of a provider's next regular payment and will be reflected on that payment's RA.
12	Will providers be subject to Office of Inspector General (OIG) administrative sanctions if they choose to waive beneficiary liability related to retroactive increases in payment rates?	Providers should review the OIG's beneficiary cost-sharing policy for circumstances such as these at http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf.