

October 31, 2017 Third Party Liability Recovery

On October 31, 2017, the Department of Human Service's (Department) Division of Third Party Liability (TPL) issued a Medicare Part A TPL/Coordination of Benefits (COB) recoupment project through its TPL contractor, Health Management Systems, Inc. (HMS) related to claims originally paid by Medical Assistance (MA). The recovery was sent to provider type 01 (inpatient facility), 31 (physician), and 34 (program exception).

- This TPL/COB Recoupment Project encompasses recipients having Medicare coverage.
- TPL is seeking assistance from medical providers in recouping funds associated with recipients who had both Medicare and MA coverage at the time the service was delivered. The Department was not aware of the coverage at the time of service delivery.
- TPL and its contractor, HMS, are continually identifying resources via eligibility data exchanges with Medicare. These are often identified after a claim is paid. It is a Federal requirement that TPL recoup payments when a third party is identified. MA is to be the payer of last resort.
- The claims in this project cover dates of service associated with Medicare resources from **January 2, 2013 through May 12, 2017**. The letter to providers related to this recoupment project includes the following: two listings of the claims being considered for recoupment; instructions for responding to the TPL/COB Recoupment Project; and, HMS contact information should the provider have questions.
- The letter also explains our expectation that the provider attempt to bill Medicare. After the deadline date (90 days from the date of the letter), TPL will recoup the money electronically. Providers are asked not to submit checks or payments as a result of any payments they receive from Medicare for the claims in this recoupment project, but they should supply documentation as explained in the project instructions to HMS to confirm receipt of denial from Medicare.
- Claims must be submitted to Medicare for processing within one year of date of service to be considered timely.
- If co-insurance and deductible amounts are due, the providers should submit a new claim for these payments to HMS according to the instructions included in the project. The new claim forms should be submitted only after the recovery has been completed. Providers will need to supply the ICN associated with the voided/retracted claim (ICN begins with Region Code '54') and the original ICN of the claim. Please send new billing forms only as the old forms will not be accepted.
- It is recommended that providers contact HMS at the toll-free number supplied in the instructions, if there are questions regarding this project.



October 31, 2017

Dear Medical Assistance Provider:

The attached claims listing is a replacement for the listing dated April 24, 2017 that was subsequently recalled. The listing includes claims paid by Medical Assistance (MA) that the Department of Human Services (Department) believes coordination of benefits should have occurred with Medicare. This identified resource was not necessarily available on the Eligibility Verification System (EVS) when services were provided. Federal regulations at 42 C.F.R. § 433.139 require that the Department recover payments when a liable third party is identified. Likewise, pursuant to 55 Pa. Code § 1101.64, *Third Party Medical Resources*, MA is the payer of last resort; therefore, Medicare Part A is the liable third party payer.

The Department has contracted with Health Management Systems, Inc. (HMS) to perform these Third Party Liability (TPL) recovery activities. HMS researched MA paid claims for the period January 2, 2013 through May 12, 2017 and identified claims associated with recipients who were eligible for Medicare Part A coverage on the dates of service. HMS, on behalf of the Department, will recover funds for these claims paid by MA that should have been billed to Medicare as the primary payer.

The Department will automatically recoup the total dollar amount/recoverable funds indicated on the attached listing under the column entitled "Recoup Amount" on a future Remittance Advice (RA) unless we receive documentation from your facility to refute the recoupment within ninety (**90**) days from the date of this notice. The Medicare Part A timely filing limits for these claims will expire one year from the date of service. Therefore, the Department strongly recommends that you bill these claims to Medicare immediately. A denial associated with the untimely filing of a claim will not be acceptable to refute the recoupment of a claim. The **Instructions - PA Medicaid Recoupment Project** are attached.

In addition, you may have received a listing that contains claims associated with recipients that have retroactive entitlement into Medicare Part A beyond the one year timely filing limit and therefore qualify for an exception to the timely filing rule. Medicare allows for the submission of these claims beyond the one year timely filing limit. The **Instructions - Retro Entitlement Claim Submissions Beyond The One-Year Timely Filing Limit** are included as well.

If recoupment is not appropriate, please notify HMS by following the attached instructions. Enclosed are two (2) copies of the claims listings as well as guidelines that must be followed to ensure necessary information is supplied to HMS. These claims must be billed to Medicare. Coverage information has been obtained from various resources. The Department recognizes that circumstances such as pre-existing conditions, exhausted benefits, or other contract limitations may exist, which could result in non-payment by Medicare; however, proof of these circumstances must be obtained and forwarded to HMS.

Please note that this letter is being sent to the same location where the Department issues payment. If necessary, please forward this letter to the appropriate department/entity and ensure it is acted upon immediately. It is imperative that the appropriate personnel receive all notification and instructions regarding this recoupment action. Your response must include all required and necessary correspondences as noted in the attached recoupment guidelines. If you expect a delay in third party processing, you must contact the phone number below **prior** to the deadline to request an extension.

PLEASE DO NOT SEND CHECKS OR CASH



All correspondence, documentation, and inquiries regarding this recoupment notice must be directed to:

Health Management Systems, Inc.
Attn: Provider Relations, PA MC
5615 High Point Drive, Suite 100
Irving, TX 75038
1-877-266-1090 (toll free) Fax: (214) 905-2064

Note: If these instructions are not followed and/or the deadlines are not met, any claim re-submissions other than for coinsurance/deductible will not be accepted. The only course of action will be to appeal to the Bureau of Hearings and Appeals as indicated on the Remittance Advice banner page.

We sincerely appreciate your cooperation in this effort to ensure appropriate expenditure of MA funds.

Sincerely,

A handwritten signature in black ink that reads "Susan Shoop". The signature is written in a cursive, flowing style.

Susan Shoop, TPL Division Director

INSTRUCTIONS – PA MEDICAID RECOUPMENT PROJECT

As stated in the attached letter from the Department, HMS is assisting the Department with its TPL recovery program. After reviewing paid claims, HMS found that the recipients associated with claims on the attached listing(s) were eligible for Medicare coverage on the date(s) of service. Please follow the instructions below when billing these claims to Medicare.

1. **DO NOT SEND CHECKS, CASH, OR A VOID REQUEST TO THE DEPARTMENT.** There will be no mechanism to stop the recoupment other than those mentioned in these instructions. Refund checks cannot be accepted. Recoverable funds will be recouped on a future Remittance Advice (RA). A banner page will accompany the RA to alert you to the recoupment.
2. If you receive payment from Medicare equal to or greater than the MA fee you were paid, **DO NOT RESPOND** to this notice. **The Department will process the claim adjustment to recover funds for any claim for which a response is not received.**
3. Two (2) copies of the list have been provided. Please retain one copy for your records and **return the second to HMS at the address shown below** with the following if you wish to refute the recovery of any claims:
 - A. Any current Medicare Explanation of Benefits (EOB)/denials that your facility receives on these claims **must** accompany the listing.
 - B. A copy of a MA remittance advice on which a prior recoupment is shown on these claims.
 - C. A contact person along with a telephone number on any reply to this notice.

****Important** - Please make a notation next to each claim that you agree should be recouped by the Department with an "R" for recoupment or with the word "Agree" to indicate that you have reviewed these claims and agree that the funds should be recouped by the Department.
4. **Only AFTER the claim is processed and the funds are retracted by the Department,** a new paper claim (black and white copy acceptable) **and EOB**, not a claim adjustment, should be submitted when MA is responsible for payment of the Medicare deductible or coinsurance charges. The new paper claim must follow all Department claim submission guidelines. In addition, the original ICN **and** the Adjustment ICN (begins with Region Code "54") should be placed on the UB-04 paper claim in Box 80 – Remarks or on the CMS -1500 in space at the bottom of the claim. The Department will process these new paper claims after the recoupment has been completed.
5. Again, **to prevent recoupment**, you should immediately:
 - A. Review your records
 - B. Bill Medicare, if you have not already done so, and then
 - C. Forward any Medicare denials or other documentation within **90 days** from the date of this notice to:
Health Management Systems, Inc.
Attn: Provider Relations, PA MC
5615 High Point Drive, Suite 100
Irving, TX 75038



If you expect a delay in Third Party processing, contact HMS below prior to the deadline to request an extension, Direct questions to Health Management Systems Provider Relations 1-877-266-1090 (toll free) or Fax: (214) 905-2064.

6. Provider/Service Location:

The Department will recover payment of these claims from the provider number and service location listed on the claims report. If you are no longer billing from this service location or want the Department to recover the payment from another service location, please contact the number listed above.

INSTRUCTIONS - RETRO ENTITLEMENT CLAIM SUBMISSIONS BEYOND THE ONE-YEAR TIMELY FILING LIMIT

The Medicare Contractor (Novitas Solutions Inc.) indicated per the IOM Publication 100-04, Chapter 1 section 70.7, that the provider must submit the bill in the following manner to qualify for the exception to the timely filing:

- Clearly label "Retroactive Entitlement"
- Request an exception to the timely filing rule
- Include the date they were notified of the retro-entitlement (HMS letter date)
- Novitas will verify the effective date through the Common Working File if the Provider is unable to obtain an official SSA letter of Medicare Entitlement from the recipient
- Date(s) of Service

If Providers have questions regarding how to submit this information electronically or through paper billing to the Medicare contractor, they can call the Medicare Provider Contact Center at: 877-235-8073.

If the claim is denied due to timely filing:

The provider must appeal the timely filing denial. The appeal must clearly state "Retroactive Entitlement" with the following supporting documentation:

- The official SSA letter of Medicare entitlement or Novitas can verify through the Common Working File (CWF)
- The effective date (start date) of the beneficiary's entitlement
- The date the provider was notified of the effective date (HMS letter date)
- Date(s) of Service
- Any documentation containing the services provided to the beneficiary and the corresponding dates of those services

Once the claim is denied for timely file and appealed; a copy of both; denial and appeal letter, must be submitted to HMS Provider Relations to temporarily place each claim on hold until processing is complete.